Northwood

CLAIM STATUS FORM

Date of Status____________________Provider Contact/Statuses: ________________

Provider Name and Tax ID: ____

Health Plan ____

Patient Name: ____

Contract/ID Number: ______________________________

Claim Number _______________________________

Procedure Code(s) Status: _______________________

Usual and Customary Charge(s): $________________

Date of Service: _________________________________

Authorization Number: __________________________

Date of First Submission: _________________________

Reason for Claim Status: ____

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Additional Documentation Submitted (YES) _________ (NO) ___________

Additional Comments:

____

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Status forms are to be used for underpayment or rejected claims only.

Mail to: Northwood, Inc.
Attn: Claims
P.O. Box 510
Warren, MI 48090-0510

CL-04
06/28/2011