Ohio Department of Medicaid

MEDICAL CLAIM REVIEW REQUEST

(Fee-for-Service Claims Only)

1. PROVIDER INFORMATION

Provider Name			
Street Address	City	State	Zip Code
Contact Person	Phone Number		

2. SUBMISSION DATE OF THIS FORM

Date	Individual Provider Number *(NPI OR 7-digit Medicaid provider number)*
Group Provider Number *(NPI OR 7-digit Medicaid provider number) (When appropriate)*	

3. CLAIM INQUIRY INFORMATION

Recipient Name		
Billing Number *(12 Digits)*	Service Date	Discharge Date

4. CLAIM HISTORY INFORMATION

Internal Control Numbers		
ICN/CLAIM ID	ICN/CLAIM ID	ICN/CLAIM ID

(Please include all necessary documentation, e.g. remittance advices, Medicare and/or Insurance EOBs)

5. EXPLANATION OF REQUEST

FOR THE OHIO DEPARTMENT OF MEDICAID USE ONLY

Each claim requires a separate ODM 06653 Medical Claim Review Request Form

Please call the Ohio Medicaid Integrated Help Desk (IHD) at 1-800-686-1516 for claim status verification.