



**Provider Claim Inquiry Form**

Please mail completed form along with documentation if required to:

Quad City Community Healthcare  
246 West Third Street Suite 100  
Davenport Iowa 52801-1931

For Provider Claim Inquiry By Telephone  
Call Customer Service at:  
563-322-8995 or 1-888-498-7224

**Confidential Fax 1-563-322-1071**

Provider Name		Date of Request
Tax ID	Individual NPI	
Address		
Contact Name	Contact Phone	

Member Name (Patient Name)	
9 character ID #	Group #

Reason for Inquiry:

Claim denied requesting detailed explanation of denial

Corrected claim (must include a copy fo the original claim determination (remit), corrected claim form, medical records and or documentation to support the change)

Coordination of Benefits (include remits or primary or secondary insurance, claim forms )

Underpayment as per provider agreement

Overpayment (if a refund check is enclosed please call customer service to obtain the correct pay to informaiton--some self insured plans require refunds to the employer account)

Other (complete the comment section below)

Notes or additional information:

Reserved/Internal QCCH Routing

Rcvd:	By:	T: S B
Rv'd:	By:	Rec:
Snt:		