First Administrators Inc (FAI)

Provider Inquiry

Required Information
Inquiries with incomplete information will be returned to the provider.

Provider Name ____ Provider TIN ____________________________

Reply Address __________________________________ City ________________________ State______ ZIP ________

Provider Contact Person _____________________________________ Contact Phone Number (____)_______________

Provider Fax Number (optional) (____)_______________________ Reply by Fax ☐ Yes ☐ No

Member Identification Number ________________________________

Member Name ____

Patient Name ____

Date(s) of Service _____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____
MM / DD / YY   MM / DD / YY   MM / DD / YY   MM / DD / YY

Total Charge $____

Document Number ____

Reason for Inquiry Request – Check all that apply
Please include a copy of provider EOB and a copy of the corrected claim when applicable.

☐ Corrected Claim – submit entire claim with corrections

Specify ____

☐ Claim Status (if no web access)

☐ Review Denied Claim – Message/Denial Code (if present) ___________

☐ Duplicate Denial in Error

☐ Underpayment/Payment Allowance Review

Other Coverage

Worker's Compensation ☐ Yes ☐ No   Date of Injury _____/_____/_____

☐ FAI Secondary to Medicare

☐ Double Coverage

Note: If the claim review requires COB or Medicare information, attach the primary carrier's EOB. If the claim review requires Worker's Comp/Subrogation information, attach Worker's Comp/Subrogation payment or denial information.

Details of Request

Date of Request _____/_____/_____

Supporting Documentation
When submitting claim for review, please attach the required documentation which may include:

- Office notes
- Physical medicine/chiropractic notes
- Pharmacy
  - NDC Number
  - Quantity
  - Description of service/drug
- Operative report(s)
- HME (Home Medical Equipment)
  - Include provider manufacturer's invoice if requesting additional allowance

* See reverse side for definitions, helpful hints and address to send form to.

Send To:

First Administrators, Inc.

- PO BOX 9900, Sioux City, IA 51102-0479
  Phone: (800) 206-0827
- PO BOX 8150, Rapid City, SD 57709-8150
  Phone: (800) 658-3073

Definitions

Reply Address – The mailing address where the reply to this inquiry should be sent.

Member – The person whose name the health coverage is under.

Document Number – Found on the top right hand side of the Explanation of Benefits

Member Identification Number – The identification number listed on the member ID card. Ex:00000JD0000F

Total Charge – The total amount of ALL charges that were included on this billing.

Helpful Hints

- Use one provider inquiry form per patient per issue
- Use the provider inquiry form when you are asking for review or adjustment of a previously processed claim and you need to submit supporting documentation for the review.