Form: 070_V01

Please complete Required(*) fields

# CLAIM REVIEW REQUEST

**Complete and return this Form to ANTHEM or MOTION PICTURE PENSION & HEALTH PLAN (MPI) as indicated below. Fields with an asterisk (*) are required.**

## Provider Data

| *Treating Physician or Provider Name | | Today's Date | # of Pages |
|---|---|---|---|
| National Provider ID Number | Tax ID Number | Contact Person | |
| Address | | | |
| City | | State | Zip |
| Email | *Phone | Ext | Fax |

## Claim Data

| *Claim Number | *Date of Service | *Patient's Name |
|---|---|---|
| *Participant's ID Number | *Participant's Name | |

## Type of Review

**Mail to: MPI**
**P.O. Box 1999**
**Studio City, CA 91614**

- ☐ Eligibility
- ☐ Information Requested on EOB
- ☐ Medical Records
- ☐ Other _____

**Mail to: Anthem**
**P.O. Box 60007**
**Los Angeles, CA 90060**

- ☐ Contract Pricing
- ☐ Corrected Claim (Diagnosis, CPT, Units, etc.)
- ☐ TIHN Referral
- ☐ Request for Primary/Secondary Explanation of Benefits
- ☐ Claim Extend

**Reason for Review – *REQUIRED** (Please state your reason in the space below)

**Attach and list the documentation provided to support or facilitate our review.** (e.g. Operative Report or Medical Records)

PLEASE NOTE: A valid Claim Number is required for processing.