

# MedCost

**Submit To: Marketing Services Unit**  
**Attention: Payer Team**  
**Fax: 336-970-2100**

MedCost's Payer Service Team is available to assist with claims in which you have exhausted all efforts to resolve and are **60 days** after the **MedCost repricing date**.

FROM : (Full Name of Sender)		Your <b>FULL &amp; COMPLETE</b> information is required to obtain a response from our research unit.
PRACTICE/FACILITY NAME:		
FTID:		
PHONE NUMBER:		
FAX NUMBER:		
EMAIL ADDRESS:		
NUMBER OF PAGES:		

## Research Request Claim Information

Employer Group Name	Employer Group Policy #	Patient's Full Name (as filed on claim)	Insured/Patient ID # (as filed on claim)	Date of Service	Total Charges Billed
What action is requested from MedCost at this time?  <input type="checkbox"/> Problematic Claim Research  <input type="checkbox"/> Payment Discrepancy	<b>REQUIRED INFORMATION:</b> Please list <b>all</b> steps taken by your office to obtain status with the claim administrator. Please include all dates. Attachments may be submitted with this form.				

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