Provider Claim Inquiry Form (CIF)

Instructions: The Provider Claim Inquiry Form (CIF) is used to resolve claim payments or denials as identified on the Remittance Advice (RA). Please carefully read the enclosed instructions prior to completing and signing the CIF. All required fields must be completed to process the Provider Claim Inquiry.

Providers must print, sign, date, and mail the form as per the instructions in the *Form Submission* section. Explanations regarding form fields are located below the form in the *Explanation of Provider Claim Inquiry Form* section. Incomplete forms will not be processed and will be returned to the provider.

*** Indicates Required Field**

PART 1 – Provider Information	
*Provider Name:	
*Service Address:	
*City:	
*State:	*ZIP Code:
*National Provider Identifier (NPI) Number:	
PART 2 – Claim Information	
*Claim Type: ☒ 01 – Pharmacy	
*Beneficiary Name:	
*Beneficiary Medi-Cal ID Number:	
*For each claim line (up to five claims per form) complete all applicable fields.	
01	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: $_____ ☐ Reconsideration ☐ Void ☐ Share of Cost (SOC) ☐ Tracer ☐ Crossover ☐ Underpayment ☐ Overpayment ☐ Attachments (Number of Attachments: _____)

02	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: $_____ ☐ Reconsideration ☐ Void ☐ Share of Cost (SOC) ☐ Tracer ☐ Crossover ☐ Underpayment ☐ Overpayment ☐ Attachments (Number of Attachments: _____)
03	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: $_____ ☐ Reconsideration ☐ Void ☐ Share of Cost (SOC) ☐ Tracer ☐ Crossover ☐ Underpayment ☐ Overpayment ☐ Attachments (Number of Attachments: _____)
04	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: $_____ ☐ Reconsideration ☐ Void ☐ Share of Cost (SOC) ☐ Tracer ☐ Crossover ☐ Underpayment ☐ Overpayment ☐ Attachments (Number of Attachments: _____)
05	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: $_____ ☐ Reconsideration ☐ Void ☐ Share of Cost (SOC) ☐ Tracer ☐ Crossover ☐ Underpayment ☐ Overpayment ☐ Attachments (Number of Attachments: _____)

*Total Attachments (Required when attachments are included):

***Remarks:** (Such as: Corrections or additional information necessary to resubmit a denied claim or request an adjustment for an underpayment or overpayment. What went wrong with the claim? What has the biller/provider done to correct the claim? What do you want Medi-Cal Rx to do with the claim? If listing multiple claims on the CIF, specify to which claim each remark applies.)

PART 3 – Provider Certification

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on this form. The signature of the provider or the Authorized Representative binds the provider to statements and conditions contained in this form.

***Signature of Provider or Authorized Representative** *(Original Signature Required; Use Blue Ink)*:**

_____

***Print Name:**

_____

***Date:**

_____

Form Submission

Print, sign, date, and mail this completed form to the address below. If you have questions about completing this form, please call the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

Medi-Cal Rx Customer Service Center
ATTN: Provider Claim Inquiries
P.O. Box 610
Rancho Cordova, CA 95741-0610

Explanation of Provider Claim Inquiry Form

The CIF is used to resolve claim payments or denials as identified on the Remittance Advice (RA). There are seven main reasons to submit a CIF:

- **Reconsideration** – A claim has been denied and a provider has information that would correct the reason for denial.
- **Void** – Reverse payment on a claim.
- **Share of Cost (SOC)** – A claim has been paid at a different amount and a provider requests a reimbursement for Share of Cost (SOC).
- **Tracer** – No record of payment or denial of a previously submitted claim exists on the RA and a provider wants to trace the status of a claim.
- **Crossover** – Refer to the *Medicare Part B Crossover Claims* section of the *Medi-Cal Rx Provider Manual* for more information.
- **Underpayment** – A claim has been underpaid and a provider requests an adjustment.
- **Overpayment** – A claim has been overpaid and a provider requests an adjustment.

Refer to the *Claim Inquiry Form* section of the *Medi-Cal Rx Provider Manual* at https://medi-calrx.dhcs.ca.gov/provider/forms for additional information regarding types of inquiries, timeliness of submission, special billing instructions, exceptions to using a CIF, acceptable attachments, completion reminders, response to CIF and completion tips.

Explanation of Form Fields

Provider Information

Provider Name: Enter the provider name.

Service Address, City, State, ZIP Code: Enter the service address for the provider.

National Provider Identifier (NPI) Number: Enter the provider's NPI number.

Claim Information

Claim Type: Defaulted to Pharmacy. For claim inquiry information for other claim types (e.g., Long Term Care, Inpatient, Outpatient, Medical), visit https://www.medi-cal.ca.gov/.

Beneficiary Name: Enter the beneficiary's first and last name.

Beneficiary Medi-Cal ID Number: Enter the beneficiary ID number that appears on the RA showing adjudication of that claim.

Prescription Number: Enter the prescription number.

Date of Service: Enter dates in a MM/DD/YYYY format.

NDC or Medical Supply Billing Code: Enter the National Drug Code (NDC) or 11-digit NDC-like medical supply billing code. When submitting an inquiry for a compound drug claim, enter zero (“0”) in place of listing the NDCs, and include each ingredient NDC with the attachment(s).

Amount Billed: Enter the dollar amount originally billed.

Reconsideration: Select this box for a denied claim reconsideration request.

Void: Select this box for a void request.

Share of Cost (SOC) Reimbursement: Select this box for a Share of Cost Reimbursement request.

Tracer: Select this box for a tracer request.

Crossover: Select this box for a Medicare Part B Crossover adjustment request.

Underpayment: Select this box for an underpayment adjustment request.

Overpayment: Select this box for an overpayment adjustment request.

Attachments: Select this box if including attachments related to the request. Note that all claim inquiries should have attachments except when requesting a tracer.

Number of Attachments: Enter the number of attachments submitted for each request.

Total Attachments: Enter the total number of attachments for all requests included on the form.

Remarks: Enter comments specific to each claim on the CIF. If listing multiple claims on the CIF, please specify to which claim each remark applies using the line numbers from the previous section.

Provider Certification

Signature of Provider or Authorized Representative: The signature of the provider or the provider’s authorized representative. An original signature is required; use blue ink.

Print Name: Print the name of the person signing the form.

Date: The date on which the form is signed.