STATE OF FLORIDA
PROVIDER INQUIRY FORM FLORIDA MEDICAID PROGRAM

P.O. BOX 7054, TALLAHASSEE, FL 32314-7054

0302

1. PROVIDER NAME AND ADDRESS	2.PROVIDER NUMBER	3.TELEPHONE NUMBER
	4. PERSON TO CONTACT IN PROVIDER'S OFFICE	5. DATE OF INQUIRY

1

6A. RECIPIENT NAME: LAST, FIRST, MI	7A. MEDICAID ID NUMBER	8A. DATES OF SERVICE

9A. PROC. CODE	10A. CHARGE	11A. REMITTANCE ADVICE DATE	12A. MED. RECORD NUMBER	13A. INTERNAL CONTROL NUMBER (ICN)

14A. NATURE OF INQUIRY

15A. FISCAL AGENT RESPONSE

2

6B. RECIPIENT NAME: LAST, FIRST, MI	7B. MEDICAID ID NUMBER	8B. DATES OF SERVICE

9B. PROC. CODE	10B. CHARGE	11B. REMITTANCE ADVICE DATE	12B. MED. RECORD NUMBER	13B. INTERNAL CONTROL NUMBER (ICN)

14B. NATURE OF INQUIRY

15B. FISCAL AGENT RESPONSE

3

6C. RECIPIENT NAME: LAST, FIRST, MI	7C. MEDICAID ID NUMBER	8C. DATES OF SERVICE

9C. PROC. CODE	10C. CHARGE	11C. REMITTANCE ADVICE DATE	12C. MED. RECORD NUMBER	13C. INTERNAL CONTROL NUMBER (ICN)

14C. NATURE OF INQUIRY

15C. FISCAL AGENT RESPONSE

FOR OFFICE USE ONLY

Received By:	Logged By:	Notes:
Date:	Date:	