State of Illinois
Department of Healthcare and Family Services

MEDICAID CLAIM INQUIRY

If you wish to have Healthcare and Family Services determine if one of your medical bills was or should have been paid by the Department, you must fill out this form completely, sign and date it, and send it to the address listed below.

You must attach evidence of pending lawsuit, threatened litigation or contact from a collection agency on behalf of a service provider. Also, attach any medical bills that you may have to help our investigation. Healthcare and Family Services will investigate your inquiry and send you a written response within 30 days. You should keep a copy of this completed form for your records.

PATIENT Information

Patient's Name: ______________________________

Patient's Social Security Number: ______________________________

Your Name: ______________________________ Phone: ______________

Address: ______________________________

City ______________ State ______________ Zip ______________

Signed: ______________________________ Date: ______________

PROVIDER Information

Name: ______________________________ Phone: ______________

(first/last name, or facility name)

Address: ______________________________

City ______________ State ______________ Zip ______________

SERVICE Information

Date(s) of Service received: ______________________________

Brief Explanation:

MAIL Completed Form To:

Illinois Department of Healthcare and Family Services
Bureau of Professional and Ancillary Services
Litigation/Collection Review
201 S. Grand Ave. East
Springfield, Illinois 62763-0002

QUESTIONS? Contact Litigation/Collection Staff at (217) 524-7319