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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Instructions:** Please complete all applicable fields. Send the completed form to ra-benwc@pa.gov and sulp@pnat.com. You may add information to the subject line, and you may include an email introduction, but it is not required since all of the information should be contained on this form. | | | | | | | | |
| **Agency Contact Information:** | | | | | | | | |
| Your Name | Agency | | Date of Occurrence/Initial Inquiry | | | | | Today’s Date |
|  |  | |  | | | | |  |
| **Claim Information:** | | | | | | | | |
| Claimant | | Inservco Claim Number | | | Adjuster | | | |
|  | |  | | |  | | | |
| **Unpaid Medical Bill Issues:** | | | | | | | | |
| Provider | | | | Dates of Service | | | Amount | |
|  | | | |  | | |  | |
| **All Other Issues:** | | | | | | | | |
| **Nature of issue: Individual Responsible:**  Timeliness Adjuster  Courtesy/Professionalism Nurse  Interest/Penalty Attorney  Overpayment Other  Other | | | | | | | | |
| **Details About the Issue:** | | | | | | | | |
|  | | | | | | | | |
| **Expected Resolution:** | | | | | | | | |
|  | | | | | | | | |
| **For Inservco Use Only:** | | | | | | | | |
| Response | | | | | | | | |
|  | | | | | | | | |
| Inservco Reviewer | | | | | | Date | | |
|  | | | | | |  | | |