Support Inquiry Form

MedLucid Solutions, LLC
Providing Clear Solutions for Medical Practices

Date of Inquiry:	Date Received:	Date Finalized:

NOTE: Date Finalized will be the date returned to sender with an appropriate response to the inquiry.

Contact Information

Name:_____

Practice/Company:_____

Address:_____

City/State/Zip:_____

Telephone:_____ Fax:_____

Topic:

Details/Description of Question:

A copy of **claim form(s)** and **EOB(s)** with PHI hidden is required for questions re: claim denials.
Documents sent include: ☐ Claim form ☐ EOB ☐ Provider's Documentation ☐ Other

Response:

Official Resources and References:

Email completed form to: **carol@medlucidsolutions.com**

☐ Bill Practice/Contact $_____ ☐ Deduct from Contract ☐ Unlimited per month ☐ No Charge

11325 Harrington Lane, Fishers, IN 46038 317.537-7553 carol@medlucidsolutions.com