MEDMUTUAL PROTECT™
A Medical Mutual® Company

Date Submitted: ____/____/_____

Pages Attached: _____

MULTIPLAN SERVICE REQUEST FORM

Billing Provider Name (Last, First, MI)	Provider ID Number
Name of Contact Person	Contact Number

Member ID		Member Name
Date of Service	Amount Billed	Patient's Name

Detailed Inquiry:

If you would like to investigate a claim processed through the MultiPlan network, please complete this form and send it to MultiPlan's Service Operations department. To aid in the research and resolution of your bill, please attach a copy of the explanation of payment, bill, a copy of the filed claim and any other pertinent information. Submission may be received via fax to (212) 780-7502 or to the following address:

MultiPlan Inc,
Service Department
115 Fifth Ave 6th Floor
New York, NY 10003

Form: MP-Rf (3/23)