MEDMUTUAL PROTECT™
A Medical Mutual® Company

Date Submitted: ____/____/_____

Pages Attached: _____

HEALTH CARE PROVIDER CLAIM INQUIRY FORM

Type of inquiry: ☐ Claim Status ☐ Rejection Questioned ☐ Payment Amount Questioned ☐ Network Availability

Billing Provider Name (Last, First, MI)		Provider ID Number	
Street Address		Name of Contact Person	
City	State	Zip	Telephone ( ) Fax ( )

Member Name		Patient's Name
Member ID		Check Number
Date of Service	Amount Billed	Date of Check or EOB
Claim Number		Place of Service

Detailed Inquiry:

Reserve National Insurance Company addresses and resolves provider inquiries related to the processing of claims as quickly as possible. If you would like us to investigate the way Reserve National has processed a particular claim, please complete this form and send it to us, along with the statement of remittance and any supporting documentation via fax to (405) 254-2111 or via mail to the following address:

MedMutual Protect
601 East Britton Road
Oklahoma City, OK 73114

Form: Prov-Inq-W
(rev 03/23)