



A **xerox** Company

Affiliated Computer Services  
Provider inquiry for the fax 907.644.8126  
Check amount Claim status

Date \_\_\_\_\_

Provider: Medicaid Contract ID+ \_\_\_\_\_ NPI \_\_\_\_\_ Provider Name \_\_\_\_\_

Contact Person \_\_\_\_\_ Provider Fax \_\_\_\_\_ Provider Phone \_\_\_\_\_

Nature of Inquiry:  Check Amount  Claim Status

ACS Response: Check Amount: \$ \_\_\_\_\_ Current RA Date: \_\_\_\_\_

For claim status inquiries, please provide the information below (Medicaid number, recipient name, date of service, et cetera):

1. \_\_\_\_\_ (Medicaid Number) \_\_\_\_\_ (Recipient Name) \_\_\_\_\_ (Date of service) \_\_\_\_\_ (Procedure code) \_\_\_\_\_ (Modifier) \_\_\_\_\_ (Billed Amount)

ACS RESPONSE: \_\_\_\_\_

2. \_\_\_\_\_ (Medicaid Number) \_\_\_\_\_ (Recipient Name) \_\_\_\_\_ (Date of service) \_\_\_\_\_ (Procedure code) \_\_\_\_\_ (Modifier) \_\_\_\_\_ (Billed Amount)

ACS RESPONSE: \_\_\_\_\_

3. \_\_\_\_\_ (Medicaid Number) \_\_\_\_\_ (Recipient Name) \_\_\_\_\_ (Date of service) \_\_\_\_\_ (Procedure code) \_\_\_\_\_ (Modifier) \_\_\_\_\_ (Billed Amount)

ACS RESPONSE: \_\_\_\_\_

4. \_\_\_\_\_ (Medicaid Number) \_\_\_\_\_ (Recipient Name) \_\_\_\_\_ (Date of service) \_\_\_\_\_ (Procedure code) \_\_\_\_\_ (Modifier) \_\_\_\_\_ (Billed Amount)

ACS RESPONSE: \_\_\_\_\_

5. \_\_\_\_\_ (Medicaid Number) \_\_\_\_\_ (Recipient Name) \_\_\_\_\_ (Date of service) \_\_\_\_\_ (Procedure code) \_\_\_\_\_ (Modifier) \_\_\_\_\_ (Billed Amount)

ACS RESPONSE: \_\_\_\_\_

COMPLETED BY \_\_\_\_\_ (ACS Provider Inquiry Specialist) \_\_\_\_\_ (Date)

\* Formerly known as Alaska Medical Assistance Provider Number  
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