Oklahoma HealthCare Authority

Request for Duplicate Provider Remittance Statement

Please complete one form per request and include $20.00 non-cash payment per request. Requests will only be processed for Remittance Advices beyond 24 months. Mail completed form(s) and payment to:

Oklahoma Health Care Authority
ATTN: Central Files
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Provider Name (Last, First, MI): _____
*Provider Billing Number: _____
Mailing Address (with zip code): _____
_____

Contact Person: _____
Telephone Number (with extension) _____

Paid Claims: (Complete A or B)

A.
Warrant #: _____
Issue Date: _____
* Pay to Provider Number: _____

B.
Deposit Date: _____
Deposit Amount: _____
*Pay to Provider Number:_____

Denied Claims:
Medicaid Client ID #: _____

*Pay to Provider Number: _____
Date of the Service:_____
Date of Denial:_____

If you filed your claim via Electronic Media (EMC), please include EMC transmittal #: _____

*** Provider Numbers as of Date of Service**

Incomplete requests will be returned.
As stated under the Federal Privacy Act, information will not be released to collection agencies.

Please allow 3-4 weeks for response.

Agency Use:
Date Received/Initial:_____/__
Date Completed: _____
Check Number: _____
Mailed: _____