Braven HEALTH

RESET

Braven Health Inquiry/Request FAX Form for Professional Providers

Professional providers may use this form to FAX Braven Health℠ claim inquiries or requests, along with pertinent supporting documentation, to **1-973-274-4159**.

Provider Name _____ Provider Tax ID Number _____

Requestor Name _____ Inquiry/Request Date _____

Requestor Phone Number _____ Requestor FAX Number _____

INQUIRY/REQUEST DETAILS

List one inquiry/request per line below. Insufficient or illegible information may result in a delay in our response. Use additional sheets as necessary.

Patient Name	Subscriber ID Number	Date of Service	Inquiry/Request Details	Horizon Reply Code	Horizon Response Details

HORIZON REPLY CODE KEY	HORIZON REPLY CODE KEY	ABBREVIATIONS KEY	ABBREVIATIONS KEY
A:Claim adjusted to pay	G: Cannot identify patient based on info provided	AR: Accounts receivable	PD: Paid
B: Claim previously paid	H: Claim has been processed	DOS: Date of service	PIF: Paid in full
C: Claim not on file	I: Claim received. Please allow 3 weeks for processing.	CHK: Check	SR: Service request
D: Submit EOB from Primary	M: Medical documentation required	CLM: Claim	SUB: Subscriber
E: Subscriber not enrolled w/Braven Health	X: Inquiry does not meet Fax criteria.	PMT: Payment	
F: Claim was rejected	Please allow 3 weeks for processing.		

Horizon Received Date _____ Horizon Response Date _____

Horizon Service Request Number _____ Horizon Representative _____