Hawaii Medicaid Fiscal Agent
1132 Bishop Street Ste. 800
Honolulu, HI 96813

FORM 239
Medicaid Correspondence Inquiry

1. Date of Inquiry	2. Provider Name (Last, First, Middle Initial)		
3. Provider Number	4. Address: ☐Pay to Address ☐Service Address		
5. Telephone Number	6. Name of Contact		
7. Claim Number (if applicable)	8. Purpose of Inquiry: ☐Questionable Payment ☐Claim Status ☐Claims Filing Procedure ☐Other * Do not use this form for claim adjustments. Send resubmissions to the appropriate Hawaii Medicaid Fiscal Agent Claim PO Box.		
9. Patient Name	10. Patient ID Number		
11. Dates of Service	12. Payment Date	13. Charge	14. Allowance
15. Remarks			

16. Response to Provider: (For Office Use Only) Completed by _____ Date _____

☐ Clam Paid on _____ Amount _____

☐ Denied on _____ Reason: _____

☐ Claim sent to Claims Dept. for reprocessing. _____

☐ Patient name and ID # not in DHS files. _____

☐ Claim is in the processing system. Please allow additional processing time. _____

☐ Claim is being researched. (We are currently working to resolve this issue.) _____

☐ Unable to match above claim data with computer file data. _____

☐ Please submit claim with:

- ☐ Medicare/TPL EOMB
- ☐ Approved waiver of filing deadline
- ☐ Other

☐ Claim date exceeds one year filling deadline

☐ Submit copy of FFS and Waiver claim to:
Hawaii Medicaid Fiscal Agent
Claims P.O. Box 1220, Honolulu, HI 96807-1220

☐ Submit filing waiver request letter to:
DHS/MQD/FO, 1001 Kamokila Blvd., Ste. 317,
Kapolei, HI 96707

Comments: _____

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