Neighborhood Health Plan OF RHODE ISLAND™

*********Only 50 Claims Per Grid*********

Date:		**Email:**	
From:		**Tax ID:**	
Provider:		**Issue #:**	
Phone:		**NHPRI email:**	**ClaimResubmission@nhpri.org**

Short Description of Issue :	Neighborhood Claim ID #	Patient Acct #	Patient Name	Member ID#	Date of Service	Claim Thru Date	Total Charges	Professional or Institutional	Final Outcome *(For NHPRI use)*

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50 Claim Limit*