**DETERMINATION LETTER**

Provider Name

**Patient Account No: Member Name: Date(s) of Service: Total Billed Amount: IEHP Claim No:**

**Date Received:**

Dear Provider:

Inland Empire Health Plan (IEHP) received an inquiry regarding the claim referenced above. Upon careful review, it has been determined that the initial decision is being **overturned** and payment will be made. Payment in the amount of $ 00**.00** is made for the following service(s):

If you require further information regarding the resolution, please contact **the IEHP Provider Call Center at (909)**

**890-2054 or (866) 223-4347**. Please use the IEHP claim number listed above as reference.

Sincerely,

Claim Specialist

Inland Empire Health Plan

1/2

**DETERMINATION LETTER**

**Patient Account No: Member Name:**

**Date(s) of Service: Total Billed Amount: IEHP Claim No:**

**Date Received:**

Dear Provider:

Inland Empire Health Plan (IEHP) received an inquiry regarding the claim referenced above. Upon careful review, it has been determined that the initial decision is being **upheld** for the following reason(s):

If you require further information regarding the resolution, please contact **the IEHP Provider Call Center at (909)**

**890-2054 or (866) 223-4347**. Please use the IEHP claim number listed above as reference.

Sincerely,

 Claim Resolution Specialist

 Inland Empire Health Plan

2/2