MARYLAND
Department of Health

Telligen®

Audiology Services Correction Request Form
Please complete the form and fax to Telligen at 888-297-4276

Date of Audiology Correction Request: _____

Provider Name: _____ **Provider Number:** _____

Patient's Name: _____

Patient's MA Number: _____

Authorization Number: _____

Date of Service: _____

Request/Case ID Number: _____

Contact Name: _____

Contact Phone Number: _____

Contact Fax Number: _____

****Contact Email Address (REQUIRED):** _____

If you only receive part of this transmission, or if transmission is illegible, please call the facsimile operator at 888-276-7075.

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Audiology Correction:	Current Information:	Change Information to:
☐ **Date of Service**		
☐ **Provider Name or Number**		
☐ **Other**		
☐ **Appeal/Hearing Outcome** (Internal Use Only)		

Patient's Last Name: _____

Telligen Reviewer: _____ **Date:** _____ ☐ **Accepted** ☐ **Rejected**