



## Provider Adjustment Request Form

Please use this form to request a review of claim payment received that does not correspond with the payment expected. Matters addressed via this form will be acknowledged as requests for adjustment only.

**Note:** Requests must be submitted within 3 months of the original disposition of the claim. Claims can be sent individually or as a batch of similar or like claims. Please complete the appropriate section for resubmission type.

### IMPORTANT: PLEASE COMPLETE ALL REQUIRED FIELDS BELOW

#### SIMPLE CLAIM ADJUSTMENT

Provider Name: _____	Provider Number: _____
Control Number: _____	Date(s): _____
Member Name: _____	Member Number: _____

#### REASON FOR ADJUSTMENT REQUEST:

- ☐ Denied for no authorization: authorization # \_\_\_\_\_ obtained
- ☐ Denied for no authorization: no referral required
- ☐ Denied for timely filing in error (please attach proof of timely filing)
- ☐ Paid to incorrect provider
- ☐ Incorrect payment amount
- ☐ Other (please explain below)

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#### BATCH SUBMISSION OF SIMILAR/LIKE CLAIMS FOR ADJUSTMENT

Provider Name: _____	Provider Number: _____
Control Claim Numbers: _____	# of Claims Attached: _____

#### Explain the Issue in Detail:

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**Note:** If a claim requires a correction, such as a valid procedure, location code or modifier, please circle the claim number on the EOP and attach a copy of the new CMS 1500 or UB 04. Mail completed form(s) and attachments to:

**Peach State Health Plan  
P.O. Box 3030  
Farmington, MO 63640**

A photocopy of this form is permissible.