Provider Adjustment Request Form

Please utilize 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)** ______________________________
(Located on your EOP directly beneath the patient name)

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:** ___________________

 # Of Claims attached_________________ **Control Claim Numbers:** _____________
(Located on your EOP- attach list or write on claim)

Explain the Issue in detail: ____
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Note: If 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 marked "RESUBMISSION". Mail completed form (s) and attachments to: P Peach State Health Plan
P.O. Box 3030
Farmington, MO 63640
A photocopy of this form is permissible.

Revised April 20, 2009