



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)

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: _____

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.