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 filling 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: _____
Control Claim Numbers: _____ # of Claims Attached _____

Explain the Issue in Detail: _____

_____

_____

_____

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.