DENTAL PROVIDER
CLAIM ADJUSTMENT REQUEST FORM

Please attach a copy of this **completed** form when returning claims to MVP Health Care® for adjustments.

Check the box that best describes the purpose for submitting the Dental Provider Claim Adjustment Request Form and attachments. If you have questions about completing this form, please call **1-800-480-5640 (option 1).**

To change or adjust the information from a previously paid/denied claim, you must attach a copy of this form with a new claim showing the adjusted information for re-submission.

Please submit **one claim per adjustment form** and **do not highlight** any fields on this form or any attachments.
An asterisk (*) denotes required information.

Today's Date: _____

Document # (Claim #)*

Member ID*

Date of Service*		Provider Name*		Tax ID*	
Member Name*		Provider ID#			
Group #		Provider NPI*			

Contact Information

Name*		Phone*		Fax*	

Claim Adjustment/Correction/Appeal (*please check only one*):

** Please attach a new dental claim, if applicable.

☐ 1. Added Services/Charges **	☐ 6. Quantity Correction **	☐ 11. Member #/Patient Correction **
☐ 2. Date of Service Correction **	☐ 7. Appeal (please explain below and include written letter of appeal and medical documentation)	☐ 12. Coinsurance/Deductible Adjustment
☐ 3. Alternate Insurance Information/EOB Coverage Attached	☐ 8. Timely Filing Issue	☐ 13. Other (please note reason below)
☐ 4. Procedure Code Correction **	☐ 9. Duplicate Adjustment	
☐ 5. COB-related Adjustment	☐ 10. Tooth #/Surface Correction	

Requested Documentation Enclosed

☐ 1. X-rays	☐ 4. Other (Explain) _____
☐ 2. Treatment Plan	
☐ 3. Orthodontic Records	

Please return this completed form and any supporting documentation to:

MVP Health Care
P.O. Box 2207
Schenectady, NY 12301-2207

For internal use only:
☐ DENTAL

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