

# 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 Claim Adjustment Request Form and attachments. ***If you have questions on completing this form, please call Provider Claims Services at (800)684-9286. West Region (Rochester and Buffalo) should call Provider Services at (585) 325-3114 or (800) 999-3920***

## THIS FORM IS NOT REQUIRED FOR THE FOLLOWING APPEALS:

- *No Authorization / Pre-Certification obtained PRIOR to service*
- *Medical Necessity*
- *Inpatient Hospital*

Mailing addresses for Appeals are at [www.mvphealthcare.com](http://www.mvphealthcare.com) on the "Contacting MVP" resource

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

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**Document # (claim#)\***

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**Member ID # \***

\_\_\_\_\_ Date of Service\*

\_\_\_\_\_ Provider Name\*

\_\_\_\_\_ Member Name\*

\_\_\_\_\_ Contact Name\*

\_\_\_\_\_ Provider ID\*

\_\_\_\_\_ Provider NPI\*

\_\_\_\_\_ Tax ID #\*

\_\_\_\_\_ Contact Phone # \*

### Coordination of Benefits Information

1. Alternate Insurance Information/EOB Coverage Attached
2. No-Fault /Workers Comp Information/EOB Attached
3. COB Related Adjustment

\_\_\_\_\_ Contact Fax # \*

### Requested Documentation Enclosed

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 1. Surgical or Surgical Modifier | <input type="checkbox"/> 4. Path/Rad Findings       | <input type="checkbox"/> 7. Transportation Run Record     |
| <input type="checkbox"/> 2. Office Notes                  | <input type="checkbox"/> 5. Code Review/Asst. Surg. | <input type="checkbox"/> 8. Manufacturer's Invoice        |
| <input type="checkbox"/> 3. Surgical/Operative Reports    | <input type="checkbox"/> 6. Follow-up Days          | <input type="checkbox"/> 9. Medical Record Review         |
|   |   | <input type="checkbox"/> 10. Evidence of Qualifying Stay  |
|   |   | <input type="checkbox"/> 11. Second Level Clinical Review |

### Check Reason for Adjustment Request (*please check only one*):

Options 1-8 require a corrected UB-92 or CMS-1500 to be attached showing all charges

- |  |  |
|--|--|
| <input type="checkbox"/> 1. Added/Deleted Charges                    | <input type="checkbox"/> 8. Copay/Deductible/Coinsurance Adjustment    |
| <input type="checkbox"/> 2. Date of Service Correction               | <input type="checkbox"/> 9. Timely Filing Issue                        |
| <input type="checkbox"/> 3. Diagnosis Correction                     | <input type="checkbox"/> 10. Duplicate Denial Error                    |
| <input type="checkbox"/> 4. CPT/Modifier Correction                  | <input type="checkbox"/> 11. Implant/High Cost Drug (Invoice Attached) |
| <input type="checkbox"/> 5. ICD-9 Procedure (UB92-Box 80) Correction | <input type="checkbox"/> 12. Provider Information Correction           |
| <input type="checkbox"/> 6. Place of Service Correction              | <input type="checkbox"/> 13. Referral or Pre-Auth Now on file- # _____ |
| <input type="checkbox"/> 7. Quantity Correction                      |  |

\*\*Please note reason for adjustment, untimely filing, or rationale for modifier use:

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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:*

- UB 04     CMS     Misc.