



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 about completing this form, please call the Customer Care Center for Provider Services at **1-800-684-9286**. Health care providers in MVP's West region (Rochester/Bufalo) may call **1-800-999-3920**. For Appeals mailing addresses, go to www.mvphealthcare.com/provider/more_contact_info.html.

DO NOT USE THIS FORM TO SUBMIT APPEALS FOR:

No Authorization / Prior Authorization Obtained Before Service Rendered / Medical Necessity / Inpatient Hospital

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: _____

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Document # (Claim #)*

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Member ID*

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

Contact Information

Name*		Phone*		Fax*	
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Coordination of Benefits Information

<input type="checkbox"/> 1. Alternate Insurance Information/EOB Coverage Attached	<input type="checkbox"/> 2. No-Fault/Workers Comp Information/EOB Attached	<input type="checkbox"/> 3. COB-related Adjustment
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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"/> 10. Evidence of Qualifying Stay
<input type="checkbox"/> 2. Office Notes	<input type="checkbox"/> 5. Code Review/Asst. Surg.	<input type="checkbox"/> 8. Manufacturer's Invoice	<input type="checkbox"/> 11. Second Level Clinical Review
<input type="checkbox"/> 3. Surgical/Operative Reports	<input type="checkbox"/> 6. Follow-up Days	<input type="checkbox"/> 9. Medical Record Review	

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

Options 1-7 require a corrected UB-04 or CMS-1500 to be attached showing all changes.

<input type="checkbox"/> 1. Added/Deleted Charges	<input type="checkbox"/> 5. Place of Service Correction	<input type="checkbox"/> 10. Implant/High-Cost Drug (Invoice Attached)
<input type="checkbox"/> 2. Date of Service Correction	<input type="checkbox"/> 6. Quantity Correction	<input type="checkbox"/> 11. Provider Information Correction
<input type="checkbox"/> 3. Diagnosis Correction	<input type="checkbox"/> 7. Copay/Deductible/Coinsurance Adjustment	<input type="checkbox"/> 12. Referral or Prior Auth Now on File:
<input type="checkbox"/> 4. CPT/Modifier/ICD Procedure Code (UB-04 Box 80) Correction	<input type="checkbox"/> 8. Timely Filing Issue	# _____
	<input type="checkbox"/> 9. Duplicate Denial Error	

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

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:		
<input type="checkbox"/> CMS-1500	<input type="checkbox"/> UB-04	<input type="checkbox"/> Misc.