Request for Research / Claim Adjustment

Complete this form, attach documentation if required and submit using instructions below.

Request Date	Provider Name	Provider Billing - or – Tax ID Number
Member Name	Member ID number *(include prefix and suffix)*	Member's Date of Birth
Claim Number –or– Charged Amount	Date of Service	Procedure Code
Provider Office Contact Name, Phone Number and/or Email Address:		

Choose one option (A1-R4) below, and indicate the reason for adjustment included in the option selected:

☐ **A1. Additional information was requested on remit:**
Information requested or denial code: ______________________________
Response: ______________________________

☐ **A2. The following fields are being corrected on the original claim:**
☐ Procedure code ☐Modifier ☐Number of service units ☐ Service date ☐Diagnosis ☐Other
Please change the above information on line number _____ from ___________ to the correct information: ______________

☐ **A3. Claim denied for a member eligibility issue; the member's files have been updated by the Health Plan.**
☐ Denied for no coverage ☐Dependent/student coverage ☐Newborn added to policy ☐Twins/triplets ☐Same name problem (Jr.vs. Sr.)
☐Other (please indicate denial): ______________________________

☐ **A4. There is an issue with primary liability (COB); supporting documentation is attached (# of pages______).**
☐Other group health coverage ☐Medicare ☐Workers Comp ☐No-Fault ☐No other health coverage applies

☐ **A5. Payment was made in error:**
☐Services not rendered ☐Wrong carrier billed ☐Wrong patient was billed ☐Duplicate payment

☐ **R1. There is an issue with the member's benefit:**
☐Incorrect co-payment ☐Auth / referral problem ☐Benefit quoted was not received ☐Service denied as non-covered benefit
Comments: ______________________________

☐ **R2. Incorrect denial was received for the service.**
☐Maximum benefit met ☐Denied as duplicate ☐Other (indicate denial): __________
Comments: ______________________________

☐ **R3. There is an issue with the payee:**
☐Claim paid wrong provider; correct provider name/number is: ______________________ ☐Provider in on-call group
☐Claim processed as in network and should be out of network ☐Claim processed as out of network and should be in network
Comments: ______________________________

☐ **R4. Incorrect payment was received for the service:**
☐Paid wrong allowance ☐Multiple procedures priced incorrectly ☐Payment not consistent with the number of services billed
Comments: ______________________________

For Univera Healthcare claims, please submit this form via: E-mail to: Univera Healthcare.EformAdj@univerahealthcare.com –or– mail to: Univera Healthcare, PO Box 23000, Rochester, NY 14692

For Univera Community Health claims, mail to: Univera Community Health, PO Box 66, Pittsford, NY 14534 or fax: 1 (888) 273-8296

Form: RFRA