

Request Date	Provider Name	Provider Billing - or - Tax ID Number
Member Name	Member ID number <i>(include prefix and suffix)</i>	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: _____

Please submit this form via: E-mail to: Univera.EformAdj@univerahealthcare.com –or– mail to:

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