



CLINICAL EDITING REVIEW REQUEST FORM

Intake No. 00000 _____

Providers Name: _____

Provider or NPI Number: _____

Provider Address: _____

Contact: _____ Phone Number: _____

Patient's Name: _____

Patient's ID Number: _____
(Include prefix and/or suffix)

Date of Service: _____ / _____ / _____
(Month) (Day) (Year)

Claim ID#: _____

Procedure Codes Questioned: _____ / _____ / _____ / _____ / _____

Issue:
 RBL (N01) INCIDENTAL (519) MUTALLY EXCLUSIVE

DUP (CDD) Mod 51 (N03) INCLUSIVE (N05)

Briefly Explain:

PLEASE ATTACH REMITTANCE AND ALL DOCUMENTATION TO BE REVIEWED

Forward completed form and supporting documentation to:

Univera Healthcare
Attn: Clinical Editing Coordinator
205 Park Club Lane
Buffalo, New York 14221
FAX: (716) 857-4633

FOR INTERNAL USE ONLY

Review status: Adjust / Uphold

Date: _____

Reviewer initials: _____