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/Buffalo) 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: _____

Document # (Claim #)*

Member ID*

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

Contact Information

Name*		Phone*		Fax*	

Coordination of Benefits Information

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

Requested Documentation Enclosed

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

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

Please note reason for adjustment or untimely filing, or note the 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:		
☐ CMS-1500	☐ UB-04	☐ Misc.

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