Physician/Provider Claim Adjustment Request Form

USE THIS FORM when submitting a corrected claim / claim adjustment, as well as the following:
- Other carrier EOB within 180 days of retraction
- Corrected claim within 180 days of denial disposition
- Corrected claim within 18 months of paid dispositions (Commercial only)

Use one form per claim to make adjustments to a claim that was previously submitted

Type of Claim:
- □ Blue Card
- □ New England Health Plan (NEHP)
- □ BCBSRI
- □ FEP
- □ Workers’ Compensation

Provider Information:
- Claim Number: ____________________________
- Provider Name: ____________________________
- National Provider Identifier (NPI): ________________

Member Information:
- Member Name: ____________________________
- Member ID: ________________________________
- Date of Service: ____________________________

Attachment:
- □ CMS-1500 Claim
- □ UB – 04 Claim Form
- □ Other Carrier Settlement*
- □ Other (please specify): ____________________________
- □ Medical Records/Supporting Documentation
- □ BCBSRI/BlueCHiP Plans Settlement*
- □ Corrected Coding Review
- □ Review with additional documentation (Other insurance settlement, etc.)
- □ Retraction request (filed in error, duplicate payment)
- □ Medical Records Review
- □ Other (please specify): ____________________________

Reason for Adjustment:
- □ Corrected claim (original submission error)
- □ Referral / authorization obtained (Documentation attached with the auth#)
- □ Review with additional documentation (Other insurance settlement, etc.)
- □ Retraction request (filed in error, duplicate payment)
- □ Other (please specify): ____________________________

Notes:
*Do not highlight line items on settlements. Use asterisks to identify relevant line items on your settlements. To comply with HIPAA, all other non-pertinent PHI on attached settlements must be blacked out.

Additional Comments: ________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please be sure to submit all supporting documentation to:
Attn: Basic Claims Administration – Inquiry Unit 00066
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street, Providence, RI 02903-2699

ADJUSTMENTS CANNOT BE MADE WITHOUT SUPPORTING DOCUMENTATION

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association