

Physician/Provider Claim Adjustment Request Form

Type of claim (check one):

- | | |
|--|--|
| <input type="checkbox"/> BCBSRI
<input type="checkbox"/> BlueCard
<input type="checkbox"/> New England Health Plan (NEHP)
(CTN, CTP, MTN, MTP, NHN, NHP, MEN, MEP) | <input type="checkbox"/> FEP
<input type="checkbox"/> Worker's compensation |
|--|--|

Date: _____	Group name: _____
Provider name: _____	Date of service: _____
National Provider Identifier (NPI): _____	Phone: (____) _____
Office contact person: _____	Member ID: _____
Member name: _____	

Attachment:

- | | |
|--|--|
| <input type="checkbox"/> CMS-1500 Claim
<input type="checkbox"/> UB – 04 Claim Form
<input type="checkbox"/> Other (please specify): _____ | <input type="checkbox"/> BCBSRI/BlueCHIP plans settlement*
<input type="checkbox"/> Another carrier settlement* |
|--|--|

*Note: Please do not shade or highlight line items when submitting settlements. Our imaging system is unable to identify shaded/highlighted areas. Please use asterisks to identify specific line items within your settlement. To comply with HIPAA, all other non-pertinent information on the settlement should be blacked out.

Reason for adjustment:

- | | | |
|--|--|--|
| <input type="checkbox"/> Not our patient
<input type="checkbox"/> Incorrect member # billed
<input type="checkbox"/> Service not performed
<input type="checkbox"/> Incorrect DOS billed
<input type="checkbox"/> Incorrect reimbursement
<input type="checkbox"/> Incorrect NPI # billed
<input type="checkbox"/> Other (please specify): _____ | <input type="checkbox"/> Incorrect denial for primary payment (submit EOB)
<input type="checkbox"/> Incorrect # of units paid
<input type="checkbox"/> Incorrect provider # billed
<input type="checkbox"/> Incorrect CPT® code | <input type="checkbox"/> Incorrect ICD-10 code
<input type="checkbox"/> Referral/pre-auth obtained
<input type="checkbox"/> Duplicate payment
<input type="checkbox"/> Corrected claim copy (original submission error)
<input type="checkbox"/> Timely filing EOB attached* |
|--|--|--|

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**

***If another carrier retracts a previous payment and provider files within appropriate timeframe of retraction with EOB showing retraction, the BCBSRI Claims Department can adjust the claim. This is not an appeal.
 ADJUSTMENTS CANNOT BE MADE WITHOUT SUPPORTING DOCUMENTATION**

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