Physician/Provider Claim Adjustment Request Form

Type of claim (check one):
☐ BCBSRI
☐ BlueCard
☐ New England Health Plan (NEHP)
  (CTN, CTP, MTN, MTP, NHN, NHP, MEN, MEP)
☐ FEP
☐ Worker’s compensation

Date: _____________________________________________
Provider name: ___________________________________
Group name: ___________________________________
National Provider Identifier (NPI): ____________________
Date of service: _________________________________
Office contact person ______________________________
Phone: (____) __________________________________
Member name: ____________________________________
Member ID: _____________________________________

Attachment:
☐ CMS-1500 Claim
☐ UB – 04 Claim Form
☐ BCBSRI/BlueCHiP plans settlement*
☐ FEP
☐ Another carrier settlement*
☐ Worker’s compensation
☐ Other (please specify): ____________________________________________________________________________

*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:
☐ Not our patient
☐ Incorrect member # billed
☐ Service not performed
☐ Incorrect DOS billed
☐ Incorrect reimbursement
☐ Incorrect NPI # billed
☐ Incorrect denial for primary payment (submit EOB)
☐ Incorrect # of units paid
☐ Incorrect provider # billed
☐ Incorrect CPT® code
☐ Incorrect ICD-10 code
☐ Referral/pre-authority obtained
☐ Duplicate payment
☐ Corrected claim copy (original submission error)
☐ Timely filing EOB attached*
☐ Other (please specify): ____________________________________________________________________________

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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