Blue Cross Blue Shield of Rhode Island

DENTAL CLAIM ADJUSTMENT REQUEST

Type of Claim (check one):

☐ BC Dental ☐ FEP

Date:_____

Provider Name:_____ Group Name:_____

NPI: _____

Office Contact Person: _____ Phone: (____)_____

Member Name:_____ Member ID:_____

Attachments:

☐ ADA Claim Form ☐ BCBSRI Settlement ☐ Another Carrier Settlement

☐ 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
☐ Service not performed
☐ Incorrect DOS billed
☐ Incorrect reimbursement
☐ Incorrect NPI billed
☐ Incorrect denial for primary payment (submit EOB)
☐ Incorrect provider # billed
☐ Incorrect CDT code
☐ Duplicate payment
☐ Incorrect member #
☐ Correct claim copy (original submission error)
☐ Other (please specify):_____

Additional Comments: _____

Please be sure to submit all supporting documentation to:

ADJUSTMENTS CANNOT BE MADE WITHOUT SUPPORTING DOCUMENTATION

Attn: Dental Claims Administration - Inquiry Unit
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903-2699