# COB Dispute & Adjustment Request Form

**Please utilize this form to request a review of claim payment/recovery. Matters addressed via this form will be acknowledged as requests for adjustment only.**

***Note: Requests must be submitted within 180 days of the original disposition or recovery of the claim.***

**All fields in the box immediately below are required information.**

**Date of Request:** ________________________
**Provider Name:**________________________
**Provider Number:**________________________

**Control Number:**________________________ **Date(s):**________________________
**(located on your EOP directly beneath the patient name)**

**Member Name:**________________________
**Member Number:**________________________

☐ **Dispute - Supporting documentation**

- **Primary carrier EOP or correspondence advising of coverage status**
- **Documentation of provider efforts to contact member/primary carrier**
- **Detailed explanation of the issue**

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☐ **Resubmission of claims to Buckeye as secondary carrier:**

- **Primary carrier EOP including explanation page(s)**
- **Corrected claim including payment by primary carrier. Please write the Buckeye claim number on the claims and attach a copy of the new CMS-1500 or UB-04 marked "RESUBMISSION."**

**Mail completed form(s) and attachments to:**
**Buckeye Community Health Plan**
**P.O. Box 6200**
**Farmington, MO 63640-3805**
**A photocopy of this form is permissible.**

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