



Provider Adjustment Request Form

Please utilize this form to request a review of claim payment received that does not correspond with the payment expected. 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 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: _____

Reason for adjustment request:

- Denied for no authorization; authorization # _____ obtained
- Denied for no authorization: no referral required
- Denied for timely filing in error (please attach proof of timely filing)
- Paid to incorrect provider
- Incorrect payment amount
- Other (please explain below)

Note: If the claim requires a correction, such as a valid procedure, location code, or modifier, please circle the claim number on the EOP, and attach a copy of the new CMS-1500 or UB-92 marked "RESUBMISSION."

Mail completed form(s) and attachments to:

For Medicaid-
Buckeye Community Health Plan
PO Box 6200
Farmington, MO 63640-3800

For Medicare-
Advantage By Buckeye Community
Health Plan
PO Box 3060
Farmington, MO 63640-3822

A photocopy of this form is permissible.

Revised October 2011