HEALTHCARE

Univera Healthcare
Request for Dental Claim Research/Adjustment/Retraction

PLEASE USE BLACK PEN TO COMPLETE THIS FORM.
DO NOT USE HIGHLIGHTER, AS IT WILL NOT BE CAPTURED WHEN DOCUMENT IS SCANNED

Request Date*	Provider Name*	Provider NPI*	Provider Tax ID*
Member Name *	Member ID Number*	Member's Date of Birth*	Claim Number*
Date of Service*	Office Contact Name*	Office Contact Phone Number*	Provider ZIP Code *
Procedure Code	Office Contact Email Address*		

***REQUIRED FIELDS**

Note: If this adjustment results in a retraction, bypass retraction/coordination of benefits (COB) hold: ❒ Yes ❒ No

- Select the appropriate adjustment/retraction request reason and attach any supporting documentation.
- Do not submit multiple members on one form. Separate forms are required for each member.
- Please do not use this form if this is an initial claim submission, OR if we requested additional information. These situations require submission of a new claim.
- **If claim involves a change to the original submission, please attach a corrected claim form along with your request**.

A1. The following fields are being corrected on the original claim

❒ Procedure code ❒ Tooth number ❒ Service date ❒ Surface ❒ Charge

❒ Other (please explain)____

Please change the above information on line number___from________to the correct information ______________________

A2. Claim denied for a member eligibility issue. The member's files have been updated by the Health Plan.

❒ Denied for no coverage ❒ Dependent/student coverage ❒ Twins/triplets ❒ Same name (Jr. vs. Sr.)

❒ Other (please explain) ____

A3. There is an issue with primary liability (coordination of benefits). Supporting documents attached.

❒ Other group dental coverage ❒ Medicare ❒ No other dental coverage applied

A4. Retraction/refund request needed as payment was made in error.

❒ Services not rendered ❒ Wrong carrier billed ❒ Wrong patient billed ❒ Duplicate payment

A5. There is an issue with the member's pre-treatment estimate:

Comments ____

A6. Incorrect denial was received for the service.

❒ Maximum benefit/frequency ❒ Denied as duplicate ❒ Other (please explain) ______________________

Comments ____

A7. There is an issue with the payee.

❒ Claim paid wrong provider ❒ Claim paid incorrect provider address ❒ Correct provider name/number is _____________

Comments ____

A8. Incorrect payment was received for the service.

❒ Paid incorrect allowance ❒ Wrong Dentemax region ❒ Wrong case type

Comments ____

To submit this form electronically via the SDS Virtual Mailbox, go to Provider.UniveraHealthcare.com/authorizations/sds-portal

To submit this form by mail, return to PO Box 211256, Eagan, MN 55121