univera HEALTHCARE an excellus company

Request for Research/Claim Adjustment/Claim 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** *(include prefix)*	**Member's Date of Birth**	
Claim Number *	**Date of Service***	**Procedure Code**	
Office Contact Name*	**Office Contact Phone Number***	**Office Contact Email Address***	
Type of Claim (Check One) ☐ **CMS-1500** ☐ **UB-04**	**Provider's ZIP Code***		

***REQUIRED FIELDS** **NOTE: If this adjustment results in a retraction, bypass MSSNY/COB hold.** ☐ Yes ☐ No

- **Select the appropriate adjustment request reason and attach any supporting documentation.**
- **Do not submit multiple members on one form. Separate forms are required for each member.**
- **Please <u>do not use this form</u> if this is an initial claim submission where determination has not been made by us OR if we requested additional information on a claim where payment has not been made. These situations require submission of a new claim.**

☐ **A1. Additional information was requested on remit:**

Information requested or denial code: ____________________ Response:____

☐ **A2. The following fields are being corrected on the original claim:**

☐ Procedure code ☐ Modifier ☐ Number of service units ☐ Service date ☐ Diagnosis ☐ Other

Please change the above information on line number ______ from ___________ to the correct information: ________________________

☐ **A3. 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 ☐ Newborn added to policy ☐ Twins/triplets ☐ Same name problem (Jr. vs. Sr.)

☐ Other (please indicate denial): ____

☐ **A4. There is an issue with primary liability (coordination of benefits). Supporting documents attached (# of pages____).**

☐ Other group health coverage ☐ Medicare ☐ Workers' Comp ☐ No-Fault ☐ No other health coverage applies

☐ **A5. Payment was made in error:**

☐ Services not rendered ☐ Wrong carrier billed – list other carrier name:_______________________ ☐ Wrong patient was billed

☐ Duplicate payment Retraction amount: $_____________

☐ **R1. There is an issue with the member's benefit:**

☐ Incorrect copayment ☐ Authorization/referral problem ☐ Benefit quoted was not received ☐ Service denied as non-covered benefit

Comments: ____

☐ **R2. Incorrect denial was received for the service.**

☐ Maximum benefit met ☐ Denied as duplicate ☐ Other (indicate denial): ____

Comments: ____

☐ **R3. There is an issue with the payee:**

☐ Claim paid wrong provider; correct provider name/number is: ___________________________ ☐ Provider in on-call group

☐ Claim processed as in-network and should be out-of-network ☐ Claim processed as out-of-network and should be in-network

Comments: ____

☐ **R4. Incorrect payment was received for the service:**

☐ Paid wrong allowance ☐ Multiple procedures priced incorrectly ☐ Payment not consistent with the number of services billed

Comments: ____

Claim adjustments, if completed, will be reflected on your next remittance and will be online at UniveraHealthcare.com/Provider.

For Univera Healthcare claims, please submit this form via email to UniveraHealthcare.EformAdj@univerahealthcare.com, or mail to Univera Healthcare, P.O. Box 211256, Eagan, MN 55121.