univera HEALTHCARE

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***	**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 do not use this form 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: _____

To submit claim adjustments online, go to Provider.UniveraHealthcare.com/claims/request-adjustment

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

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