univera HEALTHCARE
an excellus company

CLINICAL EDITING REVIEW REQUEST FORM

Date Submitted: ____________________

Select the Denial Reason: ____REBUNDLED ____INCIDENTAL ____MUTUALLY EXCLUSIVE

____DAILY MAX MET ____ADD MODIFIER ____CCI/CCM

____ MULTIPLE PROCEDURE REDUCTION

Use **Request for Claim Adjustment** form for all other claim denials.

Procedure Code(s) Questioned: ____________ /____________/____________/____________/____________

Claim ID Number: ____

Subscriber ID Number: ____

Patient's Name: ______________________________________

Date of Service:____________/____________/____________
(Month) (Day) (Year)

Provider Name: ____

Provider NPI: ____

Provider Address: ____

____

Contact Name:________________________________ **Phone Number:** ____________________________

Reason for Dispute:

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****PLEASE ATTACH REMITTANCE ADVICE AND ALL DOCUMENTATION TO BE REVIEWED****

Forward this completed form and all documentation **within 365 days of Remittance Advice** to:

Univera Healthcare
Attn: Clinical Editing Coordinator
P.O. Box 211256
Eagan, MN 55121

Reminder: Use **Request for Claim Adjustment** form for all other claim denials.