univera HEALTHCARE

CLINICAL EDITING REVIEW REQUEST FORM

For Internal Use

Date Submitted: _____

Submit only ONE claim per CE Review Request Form

*** If correcting a claim, this form/record(s) are not needed. Please use the provider web portal to electronically correct the claim in question.**

*Use of this form is for Clinical Editing denial disputes only. Please use the **Request for Claim Adjustment** form for all other claim denials.

Procedure Code(s) In Question: _____ /_____/_____ /_____ /_____
(Please, ONLY list code(s) being disputed, not all codes billed)

CE Denial / Disallow Reason Code (if known): _____
(ex: NCCI Column I/Column II Codes, Daily Max Limit/MUE, Global Period, Multiple Procedure Reduction)

Claim ID Number: _____

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

Subscriber ID #: _____ **Patient's Name:** _____

Contact Name/Address where correspondence needs to be sent:

Provider Name: _____

Contact Name: _____ **Phone Number:** _____

Provider Address: _____

_____

Provider NPI: _____ **Tax ID:** _____

Specify reason for dispute and/or claim changes being requested: _____

_____

_____

_____

Forward this completed form and all necessary documentation **within 365 days of original denial date** to:

Attn: Clinical Editing Correspondence
P.O. Box 211256
Eagan, MN 55121