ANTHEM CENTRAL REGION PROVIDER INQUIRY/REFUND/ADJUSTMENT FORM

Anthem

Date:_____

□ **Underpayment** □ **Overpayment** □ **Corrected Claim** □ **Unknown** **Type of Inquiry** □ Physician □ Facility □ Dental □ Vision

Identification Number	Member Name	Patients Name	Patient Account No.
Claim No.	Serv. Date/Adm. Date	Billed Amount	
Provider Tax ID No.	Anthem Provider No.	NPI	Office Contact Name
Provider Name	Phone No. ( )	Fax No. ( )	
Remit Address:			

□ ***Section 1*** *Check box that best describes reason for adjustment:*

□ **Late Charges** *(Fill out Section 2)*

□ **Diagnosis Change**

□ **Charge Error**
- □ Charges billed in error *(Fill out Section 2)*
- □ Charges incorrect (Fill out Section 2)

□ **Take Back Requested**

□ **No Take Back Required (Check Enclosed)**
Check No._____ Check Amt. $_____ Check Date _____
(Check return addresses on other side)

□ **Workers Compensation/Subrogation** *(Attach EOB)*
- □ Accident Date _____

□ **Duplicate Payment**
- □ Services paid twice
- □ Duplicate Claim No. _____

□ **Medicare/COB**
- □ Coinsurance incorrect *(Attach Medicare EOB or other carrier EOB)*
- □ Paid as primary *(Attach Medicare EOB or other carrier EOB)*

□ **Other Comments:**

_____

_____

□ ***Section 2*** Information to be Added, Deleted, or Replaced. **(A** for Add **– D** for Delete **– R** for Replaced**)**

Add/Delete/Replace	Date of service	CPT/Revenue Code	Line Charge	# of Units
	Total Charges: $	**Debit + (Pay More) $**	**Credit – (Take Back) $**	

Anthem's Reply To Provider

□ Claim Forwarded to Processing

□ Claim Will be Adjusted $_____
Amount Date

□ Payment Applied to Deductible $_____
Amount Date

□ Check Voided (See explanation below)

□ Check Will be Reissued

□ Please Send Operative Report

□ Secondary – Refund To Us $_____

□ Please send other carrier information

□ Claim Disposition
□ Paid □ Denied □ Processed

Date _____ Amount Paid $_____

Paid to _____

Denial Reason _____

□ No Record of Billing. Please Resubmit

□ Not an Anthem Member

□ Other _____

Explanation _____

_____

_____

Signature _____ **Date** _____