ANTHEM CENTRAL REGION PROVIDER INQUIRY/REFUND/ADJUSTMENT FORM

Anthem.

Date:

	yment		••		□ Facility □ Dental □ Vision	
Identification Number Member Nam			Patie	ents Name	Patient Account No.	
Claim No.		Ser	Serv. Date/Adm. Date		Billed Amount	
Provider Tax ID No.	o. Anthem Provider No.		NPI Offic		ce Contact Name	
Provider Name		Phone N	Phone No. ()		Fax No. ()	
Remit Address:						
□ Section 1	Check box that b	best describes	reason for adj	ustment:		
□ Late Charges (Fill out Sect	tion 2)		□ Workers Cor	npensation/Subroga	tion (Attach EOB)	
🗆 Diagnosis Change			Accident Date			
Charge Error			Duplicate Payment			
\Box Charges billed in error (Fill out Section 2)			□ Services paid twice			
□ Charges incorrect (Fill out Section 2) □ Take Back Requested			Duplicate Claim No			
Check No Check (Check return addresses on oth □ Other Comments:	Amt. <u>\$</u> Check Date er side)		□ Paid as	primary (Attach Medica	re EOB or other carrier EOB)	
□ Section 2	Information to be Added, Delet					
Add/Delete/Replace	Date of service	CP 1/Keve	enue Code	Line Charge	# of Units	
				~		
	Total Charges: \$	Debit + (P	ay More) \$	Cre	edit – (Take Back) \$	
Claim Forwarded to Processin		em's Reply T	<u>o Provider</u>	- Claim	n Disposition	
-				\square Paid \square Der	nied	
Claim Will be Adjusted <u>\$</u> Amount Date				Date	Amount Paid §	
Payment Applied to Deductible <u>\$</u>						
Check Voided (See explanation below)						
Check Will be Reissued					illing. Please Resubmit	
Please Send Operative Report			□ Not an Anthem Member			
🗆 Secondary – Refund To Us <u>\$</u>			□ Other			
Please send other carrier info	rmation					
Explanation						
Signature				Date		

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