



Provider Claim Adjustment Request Form



WHEN TO USE THIS FORM:

A **Claim Adjustment** - is a request for payment reconsideration for a paid or denied claim. Any claim for which an Explanation of Payment (EOP) was issued that was paid inappropriately, or was denied, must be resubmitted on a paper claim (not EDI) with supporting documentation as an adjustment.

Claim Adjustment Request Time Frame - All claim adjustment inquiries and requests must be made to McLaren Health Advantage (MHA) **within 90 calendar days** of the most current MHA EOP. Any inquiry or request made **after 90 calendar days** will not be given consideration. The acknowledgement of receipt date will only be considered when a completed request form and supporting documentation is received by MHA.

COMPLETE THE FOLLOWING REQUIRED INFORMATION:

Member Name: _____	ID #: _____
MHA Claim #: _____	DOS: _____
Provider Name: _____	Tax ID #: _____
	NPI #: _____
Office Contact: _____	Phone #: _____
Date Provider Claim Adjustment Request Form Submitted: _____	
Reason for Request (please check appropriate box):	

<p>For a correction to a previously submitted claim:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anesthesia Time <input type="checkbox"/> Date of Service <input type="checkbox"/> Diagnosis Code <input type="checkbox"/> Modifier <input type="checkbox"/> MS DRG <input type="checkbox"/> Place of Service <input type="checkbox"/> Procedure Code <input type="checkbox"/> Provider/Tax ID <input type="checkbox"/> Other 	<p>For reconsideration: (supporting documentation required)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Service denied for lack of authorization (attach copy of referral) <input type="checkbox"/> Service denied as other insurance primary (COB) (attach copy of primary EOB) <input type="checkbox"/> Service denied as a duplicate (attach documentation)
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Send this completed Provider Claim Adjustment Request form along with the paper claim form (not EDI) and supporting documentation to:

McLaren Health Advantage
 Attention: Customer Service
 P.O. Box 1511
 Flint, MI 48501-1511
 Or Fax to: (877) 502-1567

For questions regarding the Provider Claims Adjustment Process, call Customer Service at (888) 327-0671.
 The Provider Claims Adjustment Request form is available on our website at:

www.mclarenhealthadvantage.org