HealthPlus Claims Adjustment Form

Instructions

1. **Please complete all information in Section 1**
2. **Please indicate which type of adjustment is needed, in Section 2**
3. **Please complete Section 3 with contact information for questions.**

Note: Use this form for incorrect payments. Denials in most cases should be rebilled.
Mail to the attention of the Claims Adjustor Team Leader to: HealthPlus of Michigan, 2050 S. Linden Road, PO Box 1700, Flint, MI 48501-1700 or e-mail to ClmAdjs@healthplus.org

Section 1: General Information

Enter your HealthPlus Provider # in the space to the right: ________________________________

Member Name:_____________________________________ **Member ID #:**______________________-_____

Claim # that needs to be adjusted:_______________________________

Date of Service: (list all that apply): ____

Billed Charges: (for each line item): ____

Provider Name:____

Section 2: Type of Claim Adjustment

Appeals

- ❑ Filing limit appeal (documentation required)
- ❑ Benefit appeal
- ❑ ClaimCheck appeal (documentation required)

Coding-HPM error in processing (see original claim)

- ❑ Incorrect units (count) processed
- ❑ Incorrect diagnosis code processed
- ❑ Incorrect procedure/revenue code processed
- ❑ Incorrect location code processed
- ❑ Incorrect modifier processed
- ❑ Incorrect date of service processed
- ❑ Incorrect anesthesia time processed
- ❑ Missing or incorrect DRG processed
- ❑ Adjust claim away/corrected claim will be resubmitted.

Member

- ❑ Processed under incorrect member

Payment Amount

- ❑ Duplicate payment. Original payment on EOP dated _______________________________________
- ❑ Overpayment – Explain the reasoning. ____
- ❑ Service is not a duplicate –Explain the reasoning. ____
- ❑ COB overpayment due to two payers. Explain: ____

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Provider

- ❑ Processed under incorrect provider/provider tax identification number. Should be Pr#___________________________________

Other:

Section 3: Office Contact Information

Requested by: ____________________________ **Phone #:** ___________________ **Date**:_______________

Requestors e-mail address: ____