



PROVIDER CLAIM ADJUSTMENT REQUEST FORM

Use this form as part of CeltiCare Health Plan of Massachusetts, Inc. (CeltiCare) Claims Inquiry process to request adjustment of claim payment received that does not correspond with payment expected.

NOTE: Adjustment Requests must be submitted within 90 calendar days of the original determination of the claim (the date of your Explanation of Payment or EOP).

All fields in the box immediately below are required information.

Provider Name	Provider Tax ID#
Control Number	Date(s) of Service
Member Name	Member (RID) Number

Reason for Adjustment Request (please check):

- Claim was denied for no authorization, but authorization # _____ was obtained.
- Claim was denied for no authorization, but no authorization is required for this service.
- Claim was denied for untimely filing in error (proof of timely filing should be attached).
- Claim was paid to wrong provider
- Claim was paid for incorrect amount
- Other (please explain below)

Date of Request: _____ Requestor Name: _____

Requestor Phone Number: _____

ATTACH: A Copy of the EOP(s) with Claim(s) to be adjusted clearly circled.

NOTE: If claim(s) also required a correction, such as a valid procedure code, location code, or modifier, include a copy of that page from your EOP with the claim circled, along with a copy of the new, corrected CMS-1500 or UB04 form, marked "RESUBMISSION" across the top.

Mail completed form(s) and attachments to:

CeltiCare Health Plan of Massachusetts, Inc.
P. O. Box 3080
Farmington, MO 63640-3823

Important Notice: CeltiCare will make reasonable efforts to resolve this request within 30 calendar days of receipt. That resolution may be:

1. Reprocessing your claim and issuing a notice to you on a current EOP and payment, or
2. A determination that reprocessing is not appropriate and issuing you a letter to that effect.

This Adjustment Request form does not initiate an Informal Claim Dispute / Objection and does not push back the deadline to file a written In formal Dispute / Objection, which is Step 1 of an official complaint and must be filed within 90 calendar days of original decision shown on your EOP. For more information, see CeltiCare's Provider Manual.

(This form may be photocopied)