MDwise
A McLaren Company

MDwise Provider Claim Adjustment Request Form Directions

It is the goal of MDwise to adjudicate all provider claims in a timely and accurate manner. Providers who need to correct a claim can complete a Provider Claim Adjustment Form.

The following summarizes the Provider Claim Adjustment Form process:

When To Use the Provider Claim Adjustment Form	
A provider may submit a Provider Claim Adjustment Form if you believe a claim has been adjudicated incorrectly or a service denied inappropriately.	
Claim Adjustment Process	**Time Frames**
Within 90 calendar days from the date of the MDwise explanation of payment (EOP) provider should complete the Claim Adjustment Form and attach a copy of the corrected claim, and/or any supporting documentation for the adjustment. **Send to:** Email: **MDwiseClaims@mclaren.org** Fax: **833-540-8649**	Claim Adjustment Form must be received within 90 calendar days of the most recent MDwise explanation of payment (EOP).
Process Clarification	
The Claims Adjustment process is not available to a provider if the Dispute Process has been used and the provider was not satisfied with the outcome.	

For questions regarding the Provider Claims Adjustment Process, call Customer Service at **833-654-9192**.

The Provider Claims Adjustment Request Form is available on our website at: **mdwise.org/for-providers/forms/claims**.

G-3245 Beecher Road • Flint, Michigan • 48532 | **Phone:** 888-327-0671 | **Fax:** 877-502-1567 | McLarenHealthPlan.org

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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, can 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 MDwise within 90 calendar days of the most current MDwise 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 MDwise.

COMPLETE THE FOLLOWING REQUIRED INFORMATION:

Member Name: ______________________________

MID #: ______________________

MDwise Claim #: ______________________________

DOS: ______________________
(dates of service 1/1/19 and AFTER)

Provider Name: ______________________________

Tax ID#: ______________________

Office Contact: ______________________________

Rendering NPI #: ______________________

Date *Provider Claim Adjustment Form* Submitted: ______________

Phone #: ______________________

Email: ______________________________

Fax #: ______________________

Reason for Request (please check appropriate box & provide description below):

For a correction to a previously submitted claim:

- ☐ Date of Service
- ☐ Diagnosis Code
- ☐ Modifier
- ☐ Place of Service
- ☐ Procedure Code
- ☐ Provider/Tax ID
- ☐ Other: ______________

For reconsideration: (supporting documentation required)

- ☐ Service denied for lack of authorization (attach copy of authorization information or number)
- ☐ Service denied as other insurance primary (COB) (attach copy of primary EOB)
- ☐ Service denied as a duplicate (attach documentation)

Send this completed Provider Claim Adjustment Request Form along with a copy of the claim form and/or any supporting documentation to:

Email: **MDwiseClaims@mclaren.org**
Fax: **833-540-8649**

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