MDwise Provider Claim Adjustment Request Form Instructions

When To Use the Provider Claim Adjustment Form

A Claim Adjustment is a request for payment reconsideration for a paid or denied claim. Claim Adjustments must be submitted on a paper claim (not EDI) with supporting documentation related to the request. This includes:

- Check-related adjustments
- Non-check-related adjustments (i.e., underpayment, partial claim overpayment, and full claim overpayment)

If a claim is filed timely and is paid, including claims partially paid or paid at zero, and the provider disagrees with the reimbursement, the provider should submit a **Provider Claim Adjustment Request Form.** The claim adjustment or void/replacement must be filed within sixty (60) calendar days of notification of the claim's disposition, which MDwise considers the date of the most recent Explanation of Benefits (EOB).

- If the claim was paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider should submit the Claim Adjustment Form along with a copy of the corrected claim, and/or any supporting documentation.

- After the provider has made reasonable attempts to correct or adjust a claim, if the provider remains dissatisfied with the reimbursement, the provider should submit a claims dispute by submitting the **Claims Dispute Form** along with the documentation from the claim adjustment process, a copy of the claim, in addition to a summary of the dispute within ninety (90) calendar days from the date of the most recent EOB.

- Once a provider submits a Claims Dispute, they may not utilize a Claim Adjustment Form as an avenue to have the claim reviewed nor to extend the dispute timeframes.

Claim Adjustment Form Submissions

Claim Adjustment Form must be received within sixty (60) calendar days of the most recent MDwise Explanation of Benefits (EOB) along with a copy of the corrected claim, and/or any supporting documentation for the adjustment.

Send to:
Email: MDwiseClaims@MDwise.org
Fax: 463-426-5854

The Claims Adjustment process is not available to a provider if the Dispute Process has concluded, and the provider was not satisfied with the outcome.

MDwise
A McLaren Company

MDwise Provider Claim Adjustment Request Form

COMPLETE THE FOLLOWING REQUIRED INFORMATION:

Member Name: _____ Member Medicaid ID #: _____

MDwise Claim #: _____ DOS: _____
(Dates of Service (DOS) 1/1/19 and AFTER)

Provider Name: _____ Tax ID#: _____

Office Contact: _____ Rendering NPI #: _____

Claim Adjustment Form Submission Date: _____ 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 a copy of the 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@MDwise.org
Fax: 463-426-5854

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