Claim Adjustment Request Form VPHP01

Virginia Premier Claims
PO Box 5286 Richmond, VA 23220
Phone (804) 819-5151
Toll Free (800)727-7536
Fax Number: (804) 819-5174

Provider Name: ________________________________

Provider NPI Number: ____________________________

Insured's Medicaid ID#: ________________________

Claim Filed on: CMS 1500 UB 04

Date Sent: _____________________________________

Patient Name: ________________________________

Acct Number: ___________________________________

Please Return To:

Name: ______________________________________

Telephone: __________________________________

Provider Name and Address: ___________________

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OR Fax Number: ____________________________

Referring Provider: _______________________________

Referral/Authorization #: ___________________________

Dates of Service: _________________________________

Claim Number: ___________________________________

Charge Amt: _____________________________________

Place of Treatment: Office Inpt Hospital Home

Otpt Hospital ER Other: __________________

Reason for Request:

Adjustment Why Rejected Special Consideration Retraction/Overpayment Other ____________________

Please describe problem and requested action

Response:

Reply By: ____________________________________

Reply Date: ____________________________________

Adj01(08/24/09)