Claim Adjustment / Review Request

SENIOR Preferred (HMO)

Send form to –
Attn: Recoveries
Senior Preferred (HMO)
P.O. Box 610
Sauk City, WI 53583

or **fax to –**
(608) 643-2564

Provider Contact Information

Provider Name: Date:

Contact Name: Provider Number:

Phone Number: ( ) Ext: Email:

Fax: ( )

Member Information

Member Name: Patient Account Number:

Claim Number: Member Number:

Date of Service:

Coding Correction / Review

Please attach a copy of any necessary supporting documentation and / or a corrected claim.

- ☐ Coordination of Benefits
- ☐ Code Bundling Denial
- ☐ Corrected Charged Amount
- ☐ Corrected Date of Service
- ☐ Corrected Diagnosis, Procedure Code, Units or Modifier
- ☐ Corrected Patient Information
- ☐ Corrected Place of Service
- ☐ Corrected Provider Information
- ☐ Description of Unlisted / Misc. Code
- ☐ Duplicate / Not a Duplicate (circle one)
- ☐ Medical Records Requested: Attn:_____
- ☐ Meets Emergent Care Criteria
- ☐ Proof of Authorized Service (Authorization Number)

  _____
- ☐ Proof of Timely Filing
- ☐ Other _____