CLAIM ADJUSTMENT / REVIEW REQUEST

PROVIDER CONTACT INFORMATION

PROVIDER NAME: ___________________________  DATE: ________________________________
CONTACT NAME: ___________________________  PROVIDER NUMBER: ______________________
PHONE: ( _______ ) _______________ EXT. ______  EMAIL: ________________________________
FAX: ( _______ ) __________________________

MEMBER INFORMATION

MEMBER NAME: ___________________________  PATIENT ACCOUNT #: ______________________
CLAIM NUMBER: ___________________________  MEMBER #: ______________________________
DATE OF SERVICE: _________________________

CODING CORRECTION / REVIEW

☐ 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 _______________________________

Send form to —
For all claims EXCEPT BadgerCare Plus: Quartz, Attn: Recoveries, PO Box 211221, Eagan, MN 55121
or FAX to (608) 643-2564
For BadgerCare Plus Claims ONLY: Quartz, Attn: Recoveries, PO Box 610, Sauk City, WI 53583
or fax to (608) 643-2564

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