Quartz®

CLAIM ADJUSTMENT/REVIEW REQUEST

PROVIDER CONTACT INFORMATION

PROVIDER NAME: _____

CONTACT NAME: _____

PHONE: (_____) _____ EXT. _____

DATE: _____

PROVIDER NUMBER:_____

EMAIL: _____

FAX: (_____) _____

MEMBER INFORMATION

MEMBER NAME: _____

CLAIM NUMBER: _____

PATIENT ACCOUNT #: _____

MEMBER #: _____

DATE OF SERVICE: _____

CODING CORRECTION/REVIEW

For all claims, send form to:

Quartz, Attn: Recoveries, P.O. Box 211221, Eagan, MN 55121 or fax to (608) 643-2564

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 _____