MEDICAL/DENTAL ADJUSTMENT REQUEST FORM

Payment adjustment requests include additional or corrected data that was not on the original claim or a request for a correction of payment. A HealthPartners claim number is required. Minnesota providers must follow the AUC guide for electronic submission of adjustments.

HealthPartners

☑ Fully Insured and Self Insured Products
PO Box 1289
Minneapolis, MN 55440-1289

952-883-7770 or 7755
Fax 651-265-1230

HealthPartners

☑ Senior/Medicare Products
State of MN Assistance/Medicare Products
Federal Employee Group
PO Box 9463
Minneapolis, MN 55440-9463
952-883-7699//888-663-6464
Fax 952-883-7666

HealthPartners

☑ Dental Products
PO Box 1172
Minneapolis, MN 55440
952-883-5165//800-642-1323
Fax 651-265-1001 or 952-853-8861

Provider Name ____________________________________________

Billing Provider ID# NPI (preferred) or Tax ID ________________________________

Contact Person ________________________________ Phone/Fax/Email ________________________________

Patient Member Number ________________________ Patient Name ________________________________

HealthPartners Claim Number ________________________________

First Date of Service ____________________ Billed Amount$ __________________

Please check applicable reason(s) and attach all supporting documentation

- Coordination of Benefits
  Amount other insurance paid: $__________
  Patient Responsibility:$__________

Other Carrier Name: ________________________________
  Medicare □ Group □ Auto □ Work Comp □ Dental □ Other

- Duplicate Payment

- Late credit/charge

- Charges billed in error

- Incorrect Rendering Provider

- Incorrect Billing Provider

- Item returned

- Previously denied authorization has been approved.
  Authorization # ________________________________

Provide a complete description in the box below if selecting any of the following reasons.

- Corrected Coding
  *copy of corrected claim also required*

- E1399/Unlisted Procedure Description
  **Provide Description in Reason box below**

- Other

Complete Description of Reason for Claim Adjustment:

SUPPORTING DOCUMENTATION ATTACHED: (PLEASE CHECK BELOW)

- New completed claim (HCFA/UB/ADA/other)
- Remittance Advice Refund
- Medical Records
- Spreadsheet
- Other (describe) ________________________________