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.

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

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) ____________________________________________________________