



CLAIM ADJUSTMENT REQUEST

All Claim Adjustment Forms/New Claims must be submitted within the 90 day contractual agreement billing days
(This form is not to be used for claim inquiries or time limit overrides.)

This form is for paid claims only.

MAIL TO:

PBH Claims/Finance
245 LePhillip Court
Concord, NC 28025

**THE APPROPRIATE
RA MUST BE ATTACHED**

Provider #: _____ Provider Name: _____

Recipient

Name: _____ Social Security #: _____

**SUBMIT A COPY OF THE
RA WITH REQUEST**

Claim # or 837 Submission Date:

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Date Of Service: _____ From: ____/____/____ Billed Amount: \$ _____ Paid Amount: \$ _____ RA Date: ____/____/____
To: ____/____/____

Please check (✓) reason for submitting the adjustment request:

- Over Payment Under Payment Full Recoupment Other

Please check (✓) changes or corrections to be made:

- Units Procedure Diagnosis Code Billed Amount
 Dates of Service Patient Liability Further Medical Review
 Third Party Liability Medicare Adjustments (Attach all related Medicare Vouchers) Other

Please Specify Reason for Adjustment Request:

Signature of Sender: _____ Print Sender Name: _____

Date: _____ Phone #: _____ Email Address: _____

PBH INTERNAL USE ONLY

Processed by: _____ Date processed & Provider Contacted: ____/____/____

Review by: _____ Date reviewed: ____/____/____

Outcome of review: _____