BOSTON MEDICAL CENTER HealthNet Plan

Requesting Date: _____

Claim Adjustments and Project Form

The Provider is responsible for completing the first two sections of this form and submitting it to the Claims Resolution Unit.

Please complete this form in it's entirely for proper processing of your request and submit to the address listed at the bottom of the form. The information that is needed to process your request is outlined in the Provider Manual if further direction is necessary. **2.13 Payment Correction, Adjustment and Audit**

***** Please do not use this form for Corrected Claims or Provider Administrative Appeals*****

Corrected Claims: Please clearly mark the claim as a corrected claim and re-submit with the corrections circled in RED and mail to BMC HealthNet Plan, P.O. Box 55282, Boston, MA 02205

Provider Administrative Appeals: Please utilize the Provider Administrative Appeal form that is located in the Provider Manual. NOT utilizing the requested format may result in the rejection or a delay in the processing of your request

SECTION ONE:

Provide the following information on the billing provider for all requests:

Provider Name:	Provider ID:	Phone Number:
Fax Number:	E-mail Address:	Contact Name: Title:

SECTION TWO (FILL OUT THE APPROPRIATE INFORMATION FOR YOUR TYPE OF REQUEST):

Adjustments/Request – Return a copy of the EOB with this form and have the adjustments identified on it

☐Eligibility denial	☐Duplicate denial error	☐Utilization Management - Units issue
☐Utilization Management- denied for no authorization	☐ RA Request (only going back 12 months from the date the Plan receives this Request Form)	☐ Other (Please explain in detail in box provided below)

Further Explanation (if necessary):

Retraction Request - Return a copy of the RA with this form and have the retractions identified on it

☐Not our patient	☐COB (provide copy of prime EOB)	☐TPL (provide copy of PIP)
☐Duplicate Payment	☐Overpayment reason	☐Charges removed

☐ Other – Explain

NOTE: Project Submissions of 25 or fewer claims:
These types of projects must be submitted by contacting the Claims Resolution Unit at 1-888-566-0008 or 1-800-900-1451 or by contacting your Provider Relations Representative. Report #10319 can be provided if needed, for reconciling details of claims activity.

Please submit all requests and forms to Claims Resolution Unit Contact Information

Mailing Address:
BMC HealthNet Plan
Claims Resolution Unit
P.O. Box 55282
Boston, MA 02205

Telephone Number:
1-888-566-0008 or 1-800-900-1451
(select the claims option)