Community Behavioral Health

CLAIMS ADJUSTMENT REQUEST FORM

Please Print All Required Fields

Requestor's name _____ Date submitted _____

Provider name _____

NPI _____ Auth or Ban # _____

Recipient Name _____ Recipient ID # _____

Corrected Claim (check one box) ☐ paper (attached) ☐ CD (attached) ☐ via modem

Reason for Adjustment: (please check applicable box(es), and attach corrected claim(s))

	Invoice # of B/O claim
☐ Duplicate authorization, claims submitted and paid twice	
☐ Payment made at wrong rate	_____
☐ Payment made for incorrect level of care	_____
☐ Payment made for excessive units of service within a time period	_____
☐ Service was span billed with overlapping days on more than one claim, resulting in payment for the first claim submitted, but rejections for subsequent claims	_____
☐ Provider responded to our recovery efforts, please B/O and reprocess	
☐ Provider hasn't responded to our recovery efforts, please B/O	
☑ Back out only (please explain) _____	
☐ Unit Adjustment _____	
☐ Other (please explain) _____	

_____

ADJUSTMENT DETAIL

	Currently Paid As:	Should Be
Level of Care Code	_____	_____
Date(s) of Service	_____	_____
Units Paid	_____	_____
Rate Paid	_____	_____

(completed by CBH only)

Adjustment Request is being returned because:

☐ Units exhausted ☐ Missing or incomplete claim form ☐ Missing invoice # of paid claim

☐ Other _____

_____

Return the top two copies of this form with required support materials to:

CBH Claims Department (Attn: Adjustments) • Community Behavioral Health

801 Market Street, 7th Floor • Philadelphia, PA 19107

For more information or additional copies of this form, call CBH Claims Department at (215) 413-7125

YELLOW–Claims WHITE–Requestor