buckeye health plan

COB Dispute & Adjustment Request Form

Please utilize this form to request a review of claim payment/recovery.
Matters addressed via this form will be acknowledged as requests for adjustment only.

Note: Requests must be submitted within 180 days of the original disposition or recovery of the claim.

All fields in the box immediately below are required information.

Date of Request: _____

Provider Name: _____

Provider Number: _____

Claim Number:_____ Date(s): _____

Member Name: _____

Member Number:_____

PLEASE DO NOT ATTACH A COPY OF THE ORIGINAL CLAIM

☐ **Dispute – Supporting documentation**

- Primary carrier EOP or correspondence advising of coverage status
- Documentation of provider efforts to contact member/primary carrier
- Detailed explanation of the issue

_____

_____

_____

_____

_____

_____

☐ **Resubmission of claims to Buckeye as secondary carrier:**

- Primary carrier EOP including explanation page(s)
- Corrected claim including payment by primary carrier.

Mail completed form(s) and attachments to:

Buckeye Health Plan
P.O. Box 6200
Farmington, MO 63640

A photocopy of this form is permissible.

Updated March 2016