buckeye health plan | buckeye health plan Advantage

Provider Adjustment Request Form

Please utilize this form to request a review of claim payment received that does not correspond with the payment expected. 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 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

Reason for adjustment request:

☐ Denied for no authorization; authorization #_____ obtained
☐ Denied for no authorization: no referral required
☐ Denied for timely filing in error (please attach proof of timely filing)
☐ Paid to incorrect provider
☐ Incorrect payment amount
☐ Other (please explain below)

_____

_____

_____

_____

_____

_____

Note: If the claim requires a correction, such as a valid procedure, location code, or modifier, please circle the claim number on the EOP, and attach a copy of the new CMS-1500 or UB-92.

Mail completed form(s) and attachments to:

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

For Medicare:
Buckeye Health Plan
Advantage PO Box 3060
Farmington, MO 63640-3822

A photocopy of this form is permissible.

Updated March 2016