CLEAR FORM

# CLAIM ADJUSTMENT REQUEST FORM

Physicians Health Plan

**Please Send Adjustment Request To:**

Physicians Health Plan
PO Box 313
Glen Burnie, MD 21060-0313

***NOTE:*** *Please be advised that this form is for the purpose of submitting additional information for a processed claimed*

**Date of Request:** _____

**Provider Name:** _____

**Member Name:** _____

**Provider Number:** _____

**Member Number:** _____

**Address:** _____

**Date of Service:** _____

**Claim Number:** _____

**Contact Name and Number:** _____

## Please choose the appropriate box and description below:

☐ **COB** (please attach copies of the other carrier's Explanation of Payment)

☐ Incorrect COB Payment, Member Liability $_____

☐ Denial, Requested EOP attached for processing

☐ **Incorrect Provider Information–** Corrected Claim Attached

☐ **Incorrect Member Information–** Corrected Claim Attached

☐ **Corrected Code (s)-** Corrected Claim Attached. Describe Correction:

**Requested Information Attached** (please check one):

☐ Code Description ☐ Op-Notes ☐ Invoice
Other_____

☐ **Other** (please provide detailed information for your request):