CLAIM ADJUSTMENT REQUEST FORM

Physicians Health Plan

Please Send Adjustment Request To:

Physicians Health Plan
PO Box 399
Linthicum, MD 21090-0399

PHP FamilyCare
PO Box 439
Linthicum, MD 21090-0439

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):

_____
_____
_____