



WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

REQUEST FOR INSTITUTIONAL CLAIM ADJUSTMENT

DO NOT USE THIS FORM IN LIEU OF MEDICAL RECORDS REQUEST LETTER

Rendering Provider NPI _____ Provider Name _____
 Subscriber ID _____ Patient Name _____
 Admission From Date _____ Admission Through Date _____
 Claim # _____ Claim Total _____

Reason for Adjustment

Late Charge:

Rev Code _____	HCPCS _____	Date of Service _____	Units _____	Amount \$ _____
Rev Code _____	HCPCS _____	Date of Service _____	Units _____	Amount \$ _____
Rev Code _____	HCPCS _____	Date of Service _____	Units _____	Amount \$ _____
Rev Code _____	HCPCS _____	Date of Service _____	Units _____	Amount \$ _____

Late Credit:

Rev Code _____	HCPCS _____	Date of Service _____	Units _____	Amount \$ _____
Rev Code _____	HCPCS _____	Date of Service _____	Units _____	Amount \$ _____
Rev Code _____	HCPCS _____	Date of Service _____	Units _____	Amount \$ _____
Rev Code _____	HCPCS _____	Date of Service _____	Units _____	Amount \$ _____

Original Total: _____

Corrected Total: _____

Billed In Error – Explanation _____
 CPT / HCPCS Code Change From _____ To _____ Line(s) _____
 Diagnosis Code Change From _____ To _____ Line(s) _____
 Patient Name Change From _____ To _____ All Lines _____
 Revenue Code Change From _____ To _____ Line(s) _____
 Subscriber ID Change From _____ To _____ All Lines _____
 Type of Bill Change From _____ To _____
 Units Change – Decrease From _____ To _____
 Worker’s Compensation, Medicare, No Fault, Subrogation, Other Insurance _____
 COVID _____

***THE ADJUSTMENTS IN THIS BOX MUST HAVE SUPPORTING MEDICAL DOCUMENTATION**

*Units Change – Increase	From _____	To _____	
*Appeal – Pricing	From _____	To _____	Line(s) _____
*Appeal – Benefits	From _____	To _____	Line(s) _____

INCOMPLETE FORMS WILL BE RETURNED WITHOUT REVIEW

Contact Information Required Name _____ Phone Number _____ Ext. _____

Please send completed form to:

Blue Cross Blue Shield of Wyoming
 P.O. Box 2266
 Cheyenne, WY 82003
 Fax: 307-432-2942

Please refer to your future payment listing for updates.

1. Please Include All Applicable: Case number, date of accident, subrogation information, and/or other insurance information, and other carrier's explanation of benefits.
2. Exclude New Claims