REQUEST FOR INSTITUTIONAL CLAIM ADJUSTMENT

An independent licensee of the Blue Cross and Blue Shield Association

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

Note: *These items do not require medical documentation and should not be submitted through Availity. Please be sure to read the form instructions.*

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) ________
- ☐ Denial Code (Remit) Correction
  - ☐ Ambulance Report Line(s) ________
  - ☐ Diagnostic Report Line(s) ________
  - ☐ Emergency Service Record Line(s) ________
  - ☐ Invoice Line(s) ________
  - ☐ Itemized Bill Line(s) ________
  - ☐ Operative Report Line(s) ________
  - ☐ Progress Notes Line(s) ________
  - ☐ Records Line(s) ________
  - ☐ Treatment Plan Line(s) ________
  - ☐ Other (Only if Not Listed Above) ______________
- ☐ 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 ______________

Is this corrected claim due to a DRG Audit? ☐ Yes or ☐ No. If you selected "Yes," please fill out this box's details.

- ☐ Diagnosis Code Change
  - ☐ Principal From ________ To ________ Field # ________
  - ☐ Secondary From ________ To ________ Field # ________
  - ☐ Admitting From ________ To ________ Field # ________
- ☐ Principal Procedure Code From ________ To ________ Field # ________
  - ☐ Secondary From ________ To ________ Field # ________
- ☐ Other ______________

***THE FOLLOWING ADJUSTMENTS MUST HAVE SUPPORTING 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

Revised 07/05/2023