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) _____
- ☐ 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 _____

***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

Revised 1/15/2021