WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

REQUEST FOR PROFESSIONAL CLAIM ADJUSTMENT

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

Rendering Provider NPI # _____ Provider Name _____

Subscriber ID _____ Patient Name _____

Claim # _____ Total Charges _____

Service Dates _____

- ☐ Billed In Error – Explanation _____
- ☐ CPT / HCPCS Code Change From _____ To _____ Line(s) _____
- ☐ Date of Service 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) _____
- ☐ Diagnosis Code Pointer Change From _____ To _____ Line(s) _____
- ☐ Dollar Amount Change From _____ To _____ Line(s) _____
- ☐ Home Medical Equipment Item Returned Date of Return _____
- ☐ Modifier Change From _____ To _____ Line(s) _____
- ☐ New Provider Claim Submission From _____ To _____ Line(s) _____
- ☐ Patient Name Change From _____ To _____ All Lines _____
- ☐ Provider Number Change From _____ To _____ Line(s) _____
- ☐ Subscriber ID Change From _____ To _____ All Lines _____
- ☐ Units Change – Decrease From _____ To _____ Line(s) _____
- ☐ Worker's Compensation, Medicare, No Fault, Subrogation, Other Insurance _____
- ☐ COVID _____
- ☐ Telemedicine From _____ To _____ Line(s) _____

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

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