REQUEST FOR INSTITUTIONAL CLAIM ADJUSTMENT

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.*

WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

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) _____
  - ☐ Emergency Service Record Line(s) _____
  - ☐ Itemized Bill Line(s) _____
  - ☐ Progress Notes Line(s) _____
  - ☐ Treatment Plan Line(s) _____
  - ☐ Other (Only if Not Listed Above) _____
  - ☐ Diagnostic Report Line(s) _____
  - ☐ Invoice Line(s) _____
  - ☐ Operative Report Line(s) _____
  - ☐ Records 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 _____
- ☐ Units Change – Increase 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**

- ☐ *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 01/04/2024