Virginia Premier Elite
P.O. Box 4250
Richmond, VA 23220
Toll-Free: (877) 739-1370 (TTY:711)
www.elite.vapremier.com

Claim Adjustment Request Form

Provider Name: _____ Provider NPI Number: _____

Member ID#: _____ Claim Filed on: CMS1500 UB 04

Date Sent: _____

Patient Name: _____ Acct Number: _____

Please Return To:

Name: _____

Telephone: _____

Provider Name and Address: _____

_____

_____

OR Fax Number: _____

Referring Provider: _____

Referral/Authorization #: _____

Dates of Service: _____

Claim Number: _____

Charge Amt: _____

Place of Treatment: Office Inpt Hospital Home

Otpt Hospital ER Other:

Reason for Request:

☐ Reconsideration of TRIAGE Payment for the Hospital Visit *(Note: medical records must be attached for consideration).*

☐ Adjustment ☐ Why Rejected ☐ Special Consideration ☐ Retraction/Overpayment

Please describe problem and requested action

Response:

Reply **Reply By:** **Date:**

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