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<Virginia Premier Medicare Advantage>
<PO Box 4250>
<Richmond, VA 23220 ZIP>
<Toll-Free: (877) 739-1370 (TTY: 711)>
<www.medicare.virginiapremier.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: Referring Provider:

Telephone: Referral/Authorization #:

Provider Name and Address: Dates of Service:

Claim Number:

Charge Amt:

OR Fax Number: 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

<material ID>

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Response:

Reply Reply By: Date:

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