Claim Adjustment Request Form VPHP01

Virginia Premier Claims
PO Box 5286
Richmond, VA 23220
Phone: 1-804-819-5151
Toll Free: 1-800-727-7536

Provider Name: _____

Provider NPI Number: _____

Insured's Medicaid ID #: _____

Patient Name: _____

Claim Filed on: ☐ CMS 1500 ☐ UB 04

Date Sent: _____

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** ☐ **Other:** _____

Please describe problem and requested action:

Response:

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