



PO Box 4050 Farmington MO 63640

PROVIDER CLAIM ADJUSTMENT REQUEST FORM

Use this form as part of the Home State Health Plan claims inquiry process to request adjustment of claim payment received that does not correspond with payment expected.

NOTE: Adjustment Requests must be submitted within 180 days of the original determination of the claim (the date of your Explanation of Payment or EOP).

All fields in the box immediately below are required information

Provider Name	Provider Tax ID#
Control Number	Date(s) of Service
Member Name	Member Medicaid ID Number

Reason for Adjustment Request (please check):

- Claim was denied for no authorization, but authorization # _____ was obtained.
- Claim was denied for no authorization, but no authorization is required for this service.
- Claim was denied for untimely filing in error (proof of timely filing should be attached).
- Claim was paid to wrong provider
- Claim was paid for incorrect amount
- Other (please explain below) _____

Date of Request: _____ Requestor Name: _____

Requestor Phone Number: _____

ATTACH: A Copy of the EOP(s) with Claim(s) to be adjusted clearly circled.

NOTE: If claim(s) also required a correction, such as a valid procedure code, location code or modifier, include a copy of that page from your EOP with the claim circled, along with a copy of the new, corrected CMS-1500 or UB-04 form, marked "RESUBMISSION" across the top.

Mail completed form(s) and attachments to:

Home State Health Plan
PO Box 4050
Farmington MO 63640

Important Notice: Home State Health Plan will make reasonable efforts to resolve this request within 30 business days of receipt. That resolution may be:

1. Reprocessing your claim and issuing a notice to you on a current EOP and payment, or
2. A determination that reprocessing is not appropriate and issuing you a letter to that effect.

This Adjustment Request form does not initiate an Informal Claim Dispute / Objection and does not push back the deadline to file a written Informal Dispute / Objection, which is Step 1 of an official complaint and must be filed within 180 days of original decision shown on your EOP. For more information, see Home State Health Plan Provider Manual.

(This form may be photocopied)