# MEDICAL/DENTAL ADJUSTMENT REQUEST FORM

Payment adjustment requests include additonal or corrected data that was not on the orignal claim or a request for a correction of payment. A HealthPartners claim number is required. Minnesota providers must follow the AUC guide for electronic submission of adjustments.

**HealthPartners**
☐ Fully Insured and
Self Insured Products
PO Box 1289
Minneapolis, MN 55440-1289

952-883-7770 or 7755
Fax 651-265-1230

**HealthPartners**
☐ Senior/Medicare Products
State of MN Assistance/Medicare Products
Federal Employee Group
PO Box 9463

Minneapolis, MN 55440-9463
952-883-7699//888-663-6464
Fax 952-883-7666

**HealthPartners**
☐ Dental Products
PO Box 1172
Minneapolis, MN 55440
952-883-5165//800-642-1323
Fax 651-265-1001 or 952-853-8861

Provider Name ____________________________________________

Billing Provider ID# NPI (preferred) or Tax ID ______________________________

Contact Person ____________________ Phone/Fax/Email______________________

Patient Member Number ________________ Patient Name__________________________

HealthPartners Claim Number______________________

First Date of Service _______________ Billed Amount$____________

**Please check applicable reason(s) and attach all supporting documentation**

☐ **Coordination of Benefits**
**Amount other insurance paid: $__________**
**Patient Responsibility:$____________________**

**Other Carrier Name: _______________________**
☐ **Medicare** ☐ **Group** ☐ **Auto** ☐ **Work Comp**
☐ **Dental** ☐ **Other**

☐ **Duplicate Payment**

☐ **Late credit/charge**

☐ **Charges billed in error**

☐ **Incorrect Rendering Provider**

☐ **Incorrect Billing Provider**

☐ **Item returned**

☐ **Previously denied authorization has been approved.**
**Authorization # ___________________________**

**Provide a complete description in the box below if selecting any of the following reasons.**

☐ **Corrected Coding**
***copy of corrected claim also required***

☐ **E1399/Unlisted Procedure Description**
****Provide Description in Reason box below ****

☐ **Other**

**Complete Description of Reason for Claim Adjustment:**

**SUPPORTING DOCUMENTATION ATTACHED: (PLEASE CHECK BELOW)**

☐ New completed claim (HCFA/UB/ADA/other) ☐ Remittance Advice ☐ Refund ☐ Medical Records ☐ Spreadsheet ☐ Other (describe) ________________________________________________