Review/Adjustment Form

Important Notes:

- Complete one form for each member.
- Corrections to coding (i.e. correction to diagnosis code, procedure codes and/or modifiers) Include a copy of the updated claim
- You have 45 days from claim determination to submit the request.
- This form must be completed in full. Requests submitted without a completed form or submitted with incomplete information will be returned.

Mail To:

Community Care, Inc.
Attn: Claims Department
P.O. Box 923
Brookfield, WI 53008-0923

Fax To:

Attn: Claims Department
(414) 385-6615

Corrected Claims

Corrected claims can be submitted electronically with the appropriate resubmission type. Or submit this form with a copy of the original claim with the changes to the claim.

Provider Information

Contact Name:

Phone Number:

Contact E-mail:

Provider Name:

Address (City, St, and Zip):

Tax Identification Number (TIN):

Billing NPI Number:

Member Information

Member/Patient Name:

Member/Patient Date of Birth:

Member Account Number:

Review/Adjustment Form *(continued)*

Claim Information

DCN(s)	Date(s) of Service:	Total Billed Amount:

Reason for Review: *check box for review reason*

- ☐ Authorization Denial or Update to Authorization *(please include copy of prior authorization)*
- ☐ Non-Covered Service
- ☐ Under/Overpayment
- ☐ Coding or Modifier Denial
- ☐ Timely Filing Denial *(please include proof of timely filing)*
- ☐ Non-Contracted Provider
- ☐ Medical Documentation
  - ☐ Unlisted/Comparable Code
  - ☐ Assistant Surgeon
  - ☐ Hearing Aid Model/Description
  - ☐ Other:
- ☐ Other:

Explanation for Claims Review Request:

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Brookfield, WI 53008-0923

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- You have 45 days from claim determination to submit a review request.
- This form must be completed in full. Requests submitted without a completed form or submitted with incomplete information will be returned.
- Corrections to coding (i.e. correction to diagnosis code, procedure codes and/or modifiers) should be submitted using the original claim submission with the appropriate corrections.