HealthPartners®

☐HealthPartners
Fully Insured and Self Insured Products
P. O. 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
P.O. Box 9463
Minneapolis, MN 55440-9463
952-883-7699//888-663-6464
Fax-952-883-7666

☐HealthPartners
Dental Products
P.O. Box 1172
Minneapolis, MN 55440
952-883-5165//800-642-1323
Fax- 952-883-5160

MEDICAL/DENTAL ADJUSTMENT REQUEST FORM

DATE: _____ DATE OF SERVICE: _____
PROVIDER: _____ MEMBER NUMBER: _____
PATIENT: _____ BILLED AMOUNT: _____
CLAIM NUMBER: _____

Based upon one of the following reasons, we are requesting reconsideration of this claim.
Please check applicable reason(s) and attach all supporting documentation.

☐ Payment Adjustment

☐ Coordination of Benefits (Attach EOB (S))
Amount other insurance paid: $ _____
Patient Responsibility:$_____
☐ Medicare ☐Group ☐Auto Ins.
☐Work Comp ☐Dental ☐Other

☐Duplicate Payment
☐Item returned/Charges billed in error.
☐Can not identify the patient
☐Professional fees not processed
☐Incorrect member
☐Late credit/charge
☐Paid on ineligible charge

☐Incorrect per diem/discount applied
☐No discount applied
☐Charges billed in error
☐E1399 description: _____
☐Previously denied authorization has been approved.
☐Authorization number _____

☐ Claim Coding Appeal

☐Tooth number / surface: _____
☐Additional diagnosis: _____
☐ADA/CPT/IDC-9 code _____
should have been _____
☐Operative report/Office notes are attached which further explain services provided.
☐Multiple Modifiers 1)_____2)_____
3)_____4)_____
☐Other Coding Issues: _____
_____

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☐ Other Appeals

☐HPFIN/HPPID/NPI NUMBER: _____
☐Dental license number: _____

☐Late Claims Submission Appeal

APPEAL MUST BE MADE WITHIN 60 DAYS OF THE ORIGINAL DISALLOWED CLAIM.

Use this form to appeal claims submitted over 90 days from the date of service and for a coordination of benefits claim filed after **60 days** from the primary payers explanation of benefits or remittance advise date.

- Attach a copy of the original claim showing the original print date OR a screen print from your billing system showing the account activity and the reason why the claim is/was submitted late.

Comments on any appeal: _____

_____

Contact person _____ **Phone number_____**