CHP

CorrectionalHealthPartners®

ADJUSTMENT/APPEAL REQUEST

PLEASE INDICATE THE REQUEST YOU ARE SUBMITTING:

☐ **ADJUSTMENT** ☐ **APPEAL**

COMPLETE A SEPARATE REQUEST FOR EACH RECIPIENT AND/OR CLAIM AND INCLUDE THE FOLLOWING:

1. A copy of the claim in question
2. A copy of the voucher
3. Medicare/Third Party Liability- A copy of the Explanation of Benefits necessary
4. Other documentation

PROVIDER NAME

STREET ADDRESS

CITY, STATE, ZIP CODE

TELEPHONE NUMBER

ALL FIELDS BELOW MUST BE COMPLETED	
PATIENT IDENTIFICATION NUMBER	DATE OF SERVICE
PATIENT NAME	VOUCHER DATE
BILLING PROVIDER TAX IDENTIFICATION NUMBER	CLAIM #

PLEASE DESCRIBE THE REQUEST BELOW. DESCRIPTIONS MUST INCLUDE ANY PROCEDURE CODES/UNITS/AMOUNTS, ETC.

SIGNATURE (AUTHORIZED PROVIDER): DATE:

TO BE COMPLETED BY CORRECTIONAL HEALTH PARTNERS

☐ REPROCESS TO PAY ☐ REPROCESS TO DENY ☐ VOID ORIGINAL CLAIM

REPLY:

REVIEWED BY: DATE:

MAIL TO: **Correctional Health Partners**
PO Box 241689
Apple Valley, MN 55124-1689