

CLAIM ADJUSTMENT REQUEST FORM



**Please Send Adjustment
Request To:**

Physicians Health Plan
PO Box 853936
Richardson, TX 75085-3936

NOTE: Please be advised that this form is for the purpose of submitting additional information for a processed claim

Date of Request: _____

Provider Name: _____

Member Name: _____

Provider Number: _____

Member Number: _____

Address: _____

Date of Service: _____

Claim Number: _____

Contact Name and Number: _____

Please choose the appropriate box and description below:

COB (please attach copies of the other carrier's Explanation of Payment)

___ Incorrect COB Payment, Member Liability \$ _____

___ Denial, Requested EOP attached for processing

Incorrect Provider Information- Corrected Claim Attached

Incorrect Member Information- Corrected Claim Attached

Corrected Code (s)- Corrected Claim Attached. Describe Correction:

Requested Information Attached (please check one):

Code Description Op-Notes Invoice

Other _____

Other (please provide detailed information for your request):