Hennepin Health

Claim Adjustment/Reconsideration Request Form

This form is used when a provider:

- Has additional data that should have been submitted on the original claim or has a need to correct data that was sent incorrectly on the original claim.
- Is requesting the reconsideration of a previously adjudicated claim but there is a no additional or corrected data to be submitted

Note: Minnesota providers must follow the MN AUC guide for electronic submission of void/replacement claims.

Date:_____

Please send this form to: Hennepin Health

Attn. Adjustment Department 400 S 4th St. Ste 201
Minneapolis, MN 55415

Or fax this form to: 612-321-3786

PROVIDER INFORMATION:

Provider Name:_____
Provider NPI#: _____
Provider Address: _____
Provider Tax ID#: _____

CLAIMS INFORMATION:

Member Name: _____
Member Number: _____
Date(s) of Services: _____
Claims Number(s): _____

REASON FOR REQUEST:

- □ Timely Filing
- □ Duplicate Payment/Overpayment
- □ Corrected Claim
- □ Prior Authorization
- □ Coding Review
- □ Charges billed in error
- □ Reimbursement Rates
- □ Nursing Home Related
- □ Other
- □ E1399/Unlisted Procedure Description
- □ Item Returned
- □ Coordination of Benefits □ Medicare □ Auto □Other
- □ Incorrect Modifiers
- □ Non-Participating Provider
- □ Incorrect Elderly Wavier Obligation
- □ Incorrect Billing Provider/Rendering Provider
- □ Chemical Dependency
- □ Home Health /PCA Services

EXPLANATION:

_____

_____

_____

_____

SUPPORTING DOCUMENTATION ATTACHED:

□ Medical Records □ Remittance Advice □ Refund □ Other
□ COB

CONTACT INFORMATION:

Requestor:_____Phone Number:_____
Requestor Address:_____

TOTAL NUMBER OF PAGES:

Adjusted by: _____

Comments: _____

For Hennepin Health Claims Department Use Only