# CLAIMS ADJUSTMENT REQUEST FORM

**PCHP/PAS/PIC ONLY (PPO must be sent to the Payor)**

Any appeal received after 60 days of the date of the initial denial will not be considered. The original denial will become final. Refer to Timely Filing Policy

Today's Date:

---

**Billing Provider Information:**

Name:

Provider ID*(NPI or TID)* Number:

---

**Claim Information:**

Patient Name:

Patient ID Number:

Date(s) of Service:

Payer Claim Number:

Billed Amount:

---

**Reason for Appeal Request:**
*Complete description of reason for claim appeal. Attach all necessary documents needed for reconsideration of the claim.*

---

**Attachments:**
☐ **Remittance Advice** ☐ **Spreadsheet** ☐ **Refund** ☐ **Medical Records** ☐ **Other (describe)**

---

**Contact Information:**
Requestor: Date: Contact tŕ2yŜ:

**Provider Address:**

Contact Fax:

Contact Email: