Magellan HEALTHCARE℠

Adjustment or Dispute for Claims Request Form

Instructions

Please complete the form below. Fields with an asterisk (*) are required.
Include any necessary material to assist in processing your request. If you send documentation that includes more than one client's information, please clearly mark the claim or client information you are referring to by circling it.

Mail completed form to: **Magellan Claim Resolution**
1221 N. St. Ste. 325
Lincoln, NE 68508

For claims correction (any request to correct missing or incorrect information on a claim), use the claims correction process. Electronic claims may be submitted electronically on 837I and 837P files by indicating the value "7" in the 2300 Loop CLM05-3. When submitting the claim on paper, it must be clearly marked "corrected claim." It is helpful to include the original claim number and original date of submission. Mail corrected claims to: Magellan Behavioral Health, PO BOX 2008, Maryland Heights, MO 63043.

Date: ______

Contact Information:

*Name: ______ Phone: ______ Address: ______
(For follow up correspondence)

*Provider Name: ______ *MIS/TIN: ______ Location: ______

Claim Information:

*Member's Name: ______ *Member's Medicaid Number: ______ DOB: ______
(Only one member per request form)

☐ Single Claim ☐ Multiple "like" claims (complete attached spreadsheet) Number of claims: ______

*Claim Number: ______ *Date(s) of Service: ______ Denial Code/Reason: ______
(Ex. 123456789-0)

*Please select type of request:

☐ Claim Adjustment - (Does not initiate a Claim Dispute/Objection and does not push back the deadline to file a written dispute - Step one of an official appeal)

☐ Claim Dispute

*Reason for Adjustment or Dispute:

☐ The provider is in network
☐ Member does have eligibility
☐ Payment issues:
- ☐ Should not have co-pay taken out
- ☐ Overpayment
- ☐ Underpayment

☐ Deductions were incorrect (attach EOB from primary insurance)
☐ The Member no longer has primary insurance (attach notice of expired coverage from primary carrier)

☐ EOB was attached to original claim
☐ Provider has an authorization (attach authorization letter)
☐ Claim was submitted within expected time frame
☐ Claim was paid to wrong provider
☐ Other: ______

Detailed Description of Request:

______

Attachments (Please check if there is more information sent to go with this form.)

*Claim Number (123456789-0)	*Date(s) of Service	Denial Code/Reason

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