



**Claim Adjustment
Request Form VPHP01**

Virginia Premier Claims

PO Box 5286 Richmond, VA 23220

Phone (804) 819-5151

Toll Free (800)727-7536

Provider Name: _____

Provider NPI Number: _____

Insured's Medicaid ID#: _____

Claim Filed on: CMS 1500 UB 04

Date Sent: _____

Patient Name: _____

Acct Number: _____

Please Return To:

Name: _____

Referring Provider: _____

Telephone: _____

Referral/Authorization #: _____

Provider Name and Address: _____

Dates of Service: _____

Claim Number: _____

Charge Amt: _____

OR Fax Number: _____

Place of Treatment: Office Inpt Hospital Home

Outpt Hospital ER Other: _____

Reason for Request:

☐ Reconsideration of TRIAGE Payment for the Hospital Visit (Note: medical records must be attached for consideration).

☐ Adjustment ☐ Why Rejected ☐ Special Consideration ☐ Retraction/Overpayment ☐ Other _____

Please describe problem and requested action

Response:

Reply By: _____

Reply Date: _____

Adj01(2/28/12)