PARAMOUNT

CLAIM ADJUSTMENT/CODING REVIEW REQUEST

Please refer to reverse side for complete instructions

Section 1 - This section is required (PLEASE PRINT CLEARLY)

Date of Request: _____

Contact Name: _____

Provider Name: _____ Provider NPI: _____

Member Name: _____ Member ID Number: _____

Claim Number: _____ Date of Service: _____

☐ **Check here to indicate member has Medicare Advantage (Elite) Plan**

Section 2 – Please indicate the type of adjustment needed and **include required documents**. One form per request.

Please submit corrected claim(s) electronically with the appropriate corrected claim criteria when possible.

CLAIM CORRECTION (corrected claim required)

- ☐ Diagnosis or procedure code
- ☐ Modifier(s)
- ☐ Date of service
- ☐ Units or anesthesia time
- ☐ Place of service

PAYMENT AMOUNT (corrected claim required)

- ☐ Charged amount and/or additional or late charges
- ☐ DRG

PROVIDER/MEMBER (corrected claim required)

- ☐ Processed under incorrect member number
- ☐ Processed under incorrect provider number

PROOF OF PRIOR AUTHORIZATION OBTAINED

- ☐ Attach Copy of **pre-approved** authorization

TIMELY FILING

- ☐ Appropriate documentation that supports timely submission required for review

REFUND (attach documentation)

- ☐ Overpayment
- ☐ Take back

INVOICE

- ☐ Denied for invoice

COB

- ☐ Primary insurance **(attach primary EOP)**

CODING REVIEW REQUEST
(Medical records and copy of EOP required)

- ☐ Procedure code bundling logic denial
- ☐ Denied for chart notes
- ☐ Unlisted procedure
- ☐ Service is not a duplicate

Additional explanation:

_____

_____

_____

_____

ADJUSTMENT/CODING SUBMISSION REVIEW FORM INSTRUCTIONS

SECTION 1

1. All fields must be completed
2. The claim number from Paramount's EOP
3. Paramount's provider ID number and NPI number
4. Use one form per claim number
5. Identify if the member is an Elite member with the Plan.

SECTION 2

PLEASE CHECK THE MOST APPROPRIATE BOX- Failure to indicate one will result in the request being returned

1. **Claim Correction**
   - Requires a corrected claim
2. **Provider/Member**
   - Requires corrected claim with corrected provider or member number
3. **COB**
   - Requires a copy of primary payer EOP
4. **Timely filing**
   - Requires proof of initial submission as outlined on front page
5. **Prior Authorization**
   - Requires a copy of correct authorization
6. **Refunds**
   - Please provide full description for reason of overpayment or refund request
   - Attach documentation
7. **Payment Amount**
   - Requires a corrected claim
8. **Invoice**
   - Requires copy of invoice
9. **Coding Review Request**
   - Requires copy of coded chart, operative, or diagnostic reports
   - Requires a copy of the Paramount EOP

Please submit this form along with required documentation by mail, fax, or email to:

Mail: Paramount
P.O. Box 497
Toledo, OH 43697-0497

Fax: 405-254-2124
Email: Paramount.Docflow@medmutual.com

Disclaimer: Paramount is not responsible for any lost and/or damaged items sent by mail. Thank you.

If you have questions concerning your submission, please contact:
Provider Inquiry at 888-891-2564