Claim Adjustment Form

Provider Information

A. ☐ **Part-Provider** ☐ **Non-Part Provider**

B. ☐ Physician
☐ Facility ☐ Other: _____

C. **Type of Adjustment**
☐ Annual Form (AHA)
☐ Claim Adjustment ☐ Other: _____

D. Provider Name: _____

Tax ID: | | | | | | | | | | | Phone _____

Rendering NPI : | | | | | | | | | | | Email: _____

Billing NPI: | | | | | | | | | | |

Member Name	Member Plan ID	Plan Claim ID	Date of Service	Payment or Denied Date	Reason	Comments

Adjustment Reason

1 Co-Pay does not Applies **3** Unit Differences **5** Incorrect Provider **7** POS Correction

2 Insufficient payment **4** Incorrect Dx **6** Proveedor con cuota incorrecta **8** Other: _____

Additional Comments: _____

Important Instructions

1. Please include a copy of the claim or explanation of payments (EOP)

2. Send us corrected UB_04 or HCFA1500 Form

3. Please include any support documentation for this adjustment request

Send to:
MMM of Florida, Inc.
ATTN: CLAIMS Adjustments Request
PO Box 71305
San Juan, PR 00936-8405

Requestor Name **Requestor Signature** **Date:**