



CLAIMS ADJUSTMENT REQUEST FORM

Aspirus 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 phone:

Provider Address:

Contact Fax:

Contact Email: