Claim Adjustment Request Form OHP01

Optima Health Claims
PO Box 5286
Richmond, VA 23220
Phone 1-804-819-5151
Toll-free 1-800-881-2166
(TTY: 711)

Provider Name: _____

Provider NPI Number: _____

Insured's Medicaid ID#:

Patient Name: _____

Claim Filed on: ☐ CMS1500 ☐ UB 04

Date Sent: _____

Acct Number: _____

Please Return To:

Name: _____

Telephone: _____

Provider Name and Address:

_____

_____

_____

OR Fax Number: _____

Referring Provider: _____

Referral/Authorization #: _____

Dates of Service: _____

Claim Number: _____

Charge Amt: _____

Place of Treatment: ☐ **Office** ☐ **Inpt Hospital** ☐ **Home** ☐ **Otpt 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: _____