Adjustment/Void Request Form

I. DEMOGRAPHIC INFORMATION

Provider Name: _____ Carelon Invoice #: _____

Provider ID #: _____ Carelon Paid Date: _____

Member Name: _____ Contact Person: _____

Member ID #: _____ Telephone #: _____

II. REASON(S) FOR ADJUSTMENT / VOID

Please check all that apply.

Requested Action:

- ☐ Adjustment
- ☐ Void
- ☐ Decrease Payment
- ☐ Increase Payment

Reason:

- ☐ Incorrect Member ID
- ☐ Incorrect Date of Service
- ☐ Incorrect Units
- ☐ Incorrect $ Amount
- ☐ Other (Please Explain) _____
- ☐ Incorrect Procedure
- ☐ Incorrect Modifier
- ☐ Authorization Extended

_____

Provider Signature: _____

Date: _____

III. FOR CARELON BEHAVIORAL HEALTH USE ONLY

Status: ☐ Approve ☐ Denied ☐ Processing Code

Processor Name: _____

Date: _____

Note: Please make a copy of this form for your records.