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 ___________________________ ELITE MEMBER

Provider Name ______________________________________ Provider ID Number ___________________________
NPI Number __________________ Contact Name __________________________ Phone Number __________________
Member Name __________________________________________ Member ID Number __________________________
Claim Number __________________________________________ Date of Service __________________________

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

CLAIM CORRECTION (corrected claim required)
☐ Correction to units
☐ Correction to diagnosis code
☐ Correction to procedure code
☐ Correction to modifier
☐ Correction to date of service
☐ Correction to anesthesia time
☐ Correction to DRG
☐ Correction to place of service

REFUND
☐ Overpayment (attach documentation)
☐ Take back (attach documentation)

PAYMENT AMOUNT (corrected claim required)
☐ Additional or late charges
☐ Correction to charge amount

INVOICE
☐ Denied for invoice

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

PROVIDER/MEMBER (corrected claim required)
☐ Processed under incorrect provider number
☐ Processed under incorrect member number

COB
☐ Primary insurance (attach primary EOP)

PRIOR AUTHORIZATION
☐ Copy of authorization attached

TIMELY FILING
☐ Subrogation/workers’ compensation - copy of WC documentation attached
☐ Paramount as secondary payer - copy of primary EOP attached
☐ Originally submitted to another carrier - copy of other carrier EOP
☐ Originally billed the member as self-pay - include information that indicates how/when notified that patient had Paramount
☐ Other type of timely filing - copy of supporting documentation attached

STERILIZATION/HYSTERECTOMY/ABORTION CONSENT/CERTIFICATION - Advantage™ (Ohio Medicaid)
☐ Explain codes “BG” or “BI” (requires a corrected completed consent form JFS 03198, JFS 03199, JFS 03197)

Additional explanation:

___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

Revised 11/7/16
ADJUSTMENT/CODING SUBMISSION REVIEW FORM
INSTRUCTIONS

If Paramount has denied your claim for additional information that you feel was submitted with the original claim, please contact Provider Inquiry at 419-887-2564

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

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. Sterilization/Hysterectomy/Abortion Consent/Certification
   - Requires a corrected completed consent form [sterilization JFS 03198, hysterectomy JFS03199, or abortion JFS03197 (Medicaid rule 5101:3-21-01/5101:3-17-01)] when denied specifically “BG” or “BI”

6. Prior Authorization
   - Requires a copy of correct authorization

7. Refunds
   - Please provide full description for reason of overpayment or refund request
   - Attach documentation

8. Payment Amount
   - Requires a corrected claim

9. Invoice
   - Requires copy of invoice

10. Coding Review Request
    - Requires copy of coded chart, operative, or diagnostic reports
    - Requires a copy of the Paramount EOP

Please return this form along with required attachments to:
Paramount
P.O. Box 497
Toledo, OH 43697-0497
If you have questions concerning your submission, please contact:
Provider Inquiry at 419-887-2564, or toll free at 888-891-2564

Revised 11/7/16