



**Missouri Care™**  
H E A L T H P L A N

# Claim Adjustment Form

Date: \_\_\_\_\_

Member Name: \_\_\_\_\_

Member DCN: \_\_\_\_\_

Member DOB: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Amount Billed: \_\_\_\_\_

**Reason for Adjustment:**

- Incorrect coordination of benefits
- Duplicate payment
- Member not seen on this date of service by this provider
- Motor vehicle accident
- Provider billing error--Attach corrected claim
- Claim paid to incorrect pay to
- Claim paid incorrect dollar amount
- Charges cancelled--State reason: \_\_\_\_\_

Other--Be specific:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Attach all documentation and fax to:**  
**(866) 946-1204 (Attn: Claims)**

**Required Documentation:**  
**Corrected Claim**  
**Missouri Care Remittance Advice**  
**Primary Insurance EOB**

or return to:

**Missouri Care Health Plan**  
**Attn: Claim Adjustments**  
**2404 Forum Blvd.**  
**Columbia MO 65203**

**Person requesting adjustment:** \_\_\_\_\_

**Telephone number:** \_\_\_\_\_