



**Missouri Care**<sup>SM</sup>  
AN AETNA HEALTH PLAN

## 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 return to:  
Missouri Care Health Plan  
Attn: Claims Adjustments  
PO Box 61625  
Phoenix, AZ 85082-1625

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

Person requesting adjustment: \_\_\_\_\_  
Telephone number: \_\_\_\_\_