

# ADJUSTMENT/APPEAL REQUEST

PLEASE INDICATE THE REQUEST YOU ARE SUBMITTING:

ADJUSTMENT

APPEAL

**COMPLETE A SEPARATE REQUEST FOR EACH RECIPIENT AND/OR CLAIM AND INCLUDE THE FOLLOWING:**

1. A copy of the claim in question
2. A copy of the voucher
3. Medicare/Third Party Liability- A copy of the Explanation of Benefits
4. Other necessary documentation

PROVIDER NAME

STREET ADDRESS

CITY, STATE, ZIP CODE

TELEPHONE NUMBER

**ALL FIELDS BELOW MUST BE COMPLETED**

YOUTH IDENTIFICATION NUMBER

DATE OF SERVICE

YOUTH NAME

VOUCHER DATE

BILLING PROVIDER TAX IDENTIFICATION NUMBER

VOUCHER #

**PLEASE DESCRIBE THE REQUEST BELOW. DESCRIPTIONS MUST INCLUDE ANY PROCEDURE CODES/UNITS/AMOUNTS, ETC.**

SIGNATURE (AUTHORIZED PROVIDER):

DATE:

**TO BE COMPLETED BY PHYSICIAN HEALTH PARTNERS**

REPROCESS TO PAY

REPROCESS TO DENY

VOID ORIGINAL CLAIM

**REPLY:**

REVIEWED BY:

DATE:

MAIL TO:

**Physician Health Partners (PHP)- APPEALS  
Mental Health Institute (MHI)  
PO Box 1648  
Denver, CO 80201-1648**