



Provider Adjustment Request Form

To Submit: Fax Request to: 1-888-633-4056

SCHA Provider Services: 1-888-633-4055

Please note: If you need to void or make data changes to an existing paid claim, you do not need to complete this form. Please send a replacement (frequency 7) or void (frequency 8) claim through your clearinghouse electronically and include the original claim number.

Provider name _____ Date _____
Address _____ Requested by _____
_____ Phone # _____
Tax ID # _____ NPI/UMPI # _____

Member Name: _____
SCHA Member ID # _____
Date(s) of Service: _____
Claim Number(s): _____
Total Billed Amount: _____
Overpaid/Underpaid Amount: _____

Reason for Adjustment Request:

Please allow up to 30 days from the receipt of this form for your request to be processed.