Claims Adjustment Request Form

Aspirus Contracted Providers

Any appeal received after 60 days of the date of the initial denial will not be considered. The original denial will become final. Refer to Timely Filing Policy.

Return completed form and documentation to: Aspirus Health Plan, Attn: Claims, PO Box 1890, Southampton, PA 18966 or Fax to 763.847.4010.

PATIENT CLAIM INFORMATION

Patient Last Name	Patient First Name	Member ID	Patient Date of Birth

Address	City	State	Zip Code

Date(s) of Service	Payer Claim Number	Billed Amount

BILLING PROVIDER INFORMATION

Requester Contact Name	Email Address	Phone Number	Fax Number

Billing Provider Name	NPI

Billing Provider Address	City	State	Zip Code

REASON FOR APPEAL REQUEST

Complete description of reason for claim appeal. Attach all necessary documents needed for reconsideration of the claim.

ATTACHMENTS

☐ Remittance Advice ☐ Spreadsheet ☐ Refund ☐ Spreadsheet ☐ Medical Records
☐ Other *(describe)*