



CLINICAL EDITING REVIEW REQUEST FORM

Date Submitted: _____

Select the Denial Reason: _____ REBUNDLED _____ INCIDENTAL _____ MUTUALLY EXCLUSIVE

Use **Request for Claim Adjustment** form for all other claim denials.

_____ DAILY MAX MET _____ ADD MODIFIER _____ CCI/CCM

_____ MULTIPLE PROCEDURE REDUCTION

Procedure Code(s) Questioned: _____ / _____ / _____ / _____ / _____

Claim ID Number: _____

Subscriber ID Number: _____

Patient's Name: _____

Date of Service: _____ / _____ / _____
(Month) (Day) (Year)

Provider Name: _____

Provider NPI: _____

Provider Address: _____

Contact Name: _____ **Phone Number:** _____

Reason for Dispute:

****PLEASE ATTACH REMITTANCE ADVICE AND ALL DOCUMENTATION TO BE REVIEWED****

Forward this completed form and all documentation **within 120 days of Remittance Advice** to:

Excellus BlueCross BlueShield
Attn: Clinical Editing Coordinator
P.O. Box 22999
Rochester, NY 14692

Reminder: Use **Request for Claim Adjustment** form for all other claim denials.