Claim Information/Adjustment Request 151 Form for Medicaid Claims

Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

Mail **Reconsiderations** to:
HealthKeepers, Inc.
P.O. Box 62404
Virginia Beach, VA 23466-2404

Use this form to (check all that apply):
□ Attach additional information
□ Overpayment adjustment request
□ Underpayment adjustment request
□ Other: _____

*This form **should not** be used to inquire about services that have been denied as not medically necessary or as investigational. Refer to Provider Education section on the website* **mediproviders.anthem.com/va** *for instructions about how to file an appeal.*

Complete all sections of this form.

Provider number: _____

Provider's name and address: _____

_____

Claim filed: □ Paper □ Electronic Date sent: _____
Claim type: □ Professional □ Facility

Claim information:
Onset date: ___/___/___ Consult date: ___/___/___

Check appropriate box: □ LMP □ Accident □ Illness (first symptom)

Place of treatment: □ Office □ Inpatient hospital □ Outpatient hospital
□ Home □ Other (describe): _____

_____

Insured's ID number: _____
(as shown on patient's ID card)

Patient's name: _____

Claim number: _____ Charge: _____

Patient's account number: _____

Please return to:

Name: _____

Telephone number: _____

Other insurance (if applicable to inquiry) Insurance company:
_____

Insured's name: _____ Policy number: _____ Effective date: _____

Name of referring physician: _____ Dates of Service: _____

Group name or number: _____

837 Attachment control number: _____

Briefly describe claim issue and action requested:

(For internal use only)

Reply date: _____ Name: _____ Inquiry number (for internal use only): _____

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