

MEDICA ADJUSTMENT REQUEST FORM

*To be used when a payment has already been made by Medica but a change is necessary
and within 180 days of the original provider remittance advice (PRA) check date,
unless a provider contract indicates otherwise.*

MEDICA®

DATE: _____

PROVIDER NAME: _____

PROVIDER NUMBER: _____

PROVIDER ADDRESS: _____

PLEASE SEND TO APPROPRIATE ADDRESS BELOW:

Medica (all products except SelectCare & LaborCare)
PO Box 30990
Salt Lake City UT 84130

CLAIM INFORMATION:

Medica Member Name: _____

Medica Member ID Number: _____

Date(s) of Service: _____

Claim Number: _____

Reason for Adjustment Request: _____

Refund Check Attached: Yes No

Attachments Included: Yes No Number of Pages in the Attachment(s): _____

Type of Attachments: (check all that apply) EOB EOMB Spreadsheet PRA Other

A COPY OF THE PRA MAY BE ATTACHED TO EXPEDITE THIS ADJUSTMENT.

Requested By: _____ Phone Number: _____

Medica Adjustment Department Use Only

Adjustment Code: _____ Adjusted By: _____

Comments: _____