☐ Medicare ☐ Commercial

Provider Claim Adjustment Request

NOTE: Complete each section of this form. Please print clearly, using black or blue ink only. Incomplete information may delay or cause your request to be returned unprocessed.

Date:____________________

Type of Request

- ☐ Overpayment Correspondence (Check enclosed)
- ☐ Overpayment Correspondence (No Check enclosed)
- ☐ Fee/Contract Schedule
- ☐ Procedure Code Audit
- ☐ COB/EOP
- ☐ Timely Filing (supporting documents enclosed)
- ☐ Medical Necessity Appeal (medical records enclosed)

If the claim does not meet the criteria for one the above categories, contact Provider Support Services at 800-996-8401

Provider Information

Requester/Contact Name:	Telephone Number:
Provider Number:	Provider Name:
Mailing Address: Street or P. O. Box / City / State / Zip Code	
Fax Number:	

Patient Information

Identification Number:	Patient Name:
Claim Number:	DOB
Service Date(s):	

Detailed Explanation

Send completed form to: SummaCare, Attn: Mailroom, P.O. Box 3620, Akron, OH 44309-3620
Fax to 330-996-8490 or Email contactproviderservices@summacare.com