Corewell Health™

PROVIDER ADJUSTMENT (BILLED SERVICES)

Date of request ______________________ Site requesting ______________________

Name of person requesting ______________________ Phone number to reach you at ______________________

Patient name ______________________ Account/MRN ______________________

Date of birth ______________________ Insurance ______________________

Date of service ______________________ CPT/Procedure code(s) ______________________

Check appropriate box

- ☐ Test do over
- ☐ Service couldn't be completed
- ☐ Duplicate labs conducted at Corewell Health
- ☐ Service repeated due to equipment/power failure
- ☐ Wrong service conducted in error
- ☐ Other ______________________
- ☐ Service(s) incorrectly ordered
- ☐ Scheduling error
- ☐ Lab/Services done too early
- ☐ Patient billed but never received services

Reason for change/adjustment request or other scenario not listed

Adjustment amount ______________________

Physician/Provider signature **(required)** ______________________

Note That We Will Not Accept Physician Signature Stamps

Email This Form To: Customer Service - PLST customerserviceplst@corewellhealth.org

You will be contacted once the request has been reviewed and processed. Form will be scanned into the M drive.

Independent (non-Corewell Health) Provider Offices: If this is for a diagnosis update and insurance needs to be re-billed, please fax completed form to 616-643-9434.

Lab ABN Coding Inquiry Helpline: LabABNCodingInquiryHelpline@spectrumhealth.org

General Coding Inquiry Helpline: CodingInquiryHelpline@spectrumhealth.org

Corewell Health and Corewell Health Medical Group:

Facility coding inquiries should be sent via Epic using the following Billing Indicator: Coding Review Needed

©Corewell Health

X22990 (8/23)