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CLAIM PRICING CORRECTION – REQUEST FORM

Please print and return completed form to the network along with a copy of the original (or corrected) CMS1500 or UB92 claim to request pricing correction.

Today's Date: _____

PROVIDER INFORMATION

Requesters Name _____

Ph # _____ Fax # _____

Physicians Name _____

Tax ID # _____ NPI # _____

PATIENT INFORMATION

Patient ID # _____ Group Policy # _____

Patient Name _____

Parents Name, if patient is a minor _____

Date of Service _____ Claim Billed Amount \$ _____

REASON FOR REQUESTING CORRECTION TO CLAIM PRICING:
