Neighborhood Health Plan OF RHODE ISLAND™

Adjustment Request Form

910 Douglas Pike, Smithfield, RI 02917 : 1-800-963-1001 : nhpri.org

- To request an adjustment, the following items **must be submitted for each individual claim**:
  - ✓ A completed Adjustment Request Form
  - ✓ Claim number
  - ✓ Remittance Advice, Explanation of Benefits, or Coordination of Benefits documentation (as applicable)
  - ✖ **Adjustment requests with claims attached will be returned to the sender.**

1. Please complete the following:

Member Name / ID #	
Claim number	
Date(s) of service	

Provider Name / NPI#	
Provider Address	
Contact Name	
Contact Phone # / E-mail	

2. Adjustment reason:

- ☐ Claim Processed Incorrectly
- ☐ Coordination of Benefits
- ☐ Duplicate Claim
- ☐ NOPCP Denial
- ☐ Retraction of Payment (indicate which claims)
- ☐ Other: _____

3. Description of request:

4. **Please mail completed form and documentation to:** **Neighborhood Health Plan of RI**
Attn: Provider Claims Services
PO Box 28259
Providence, RI 02908-3700

If you have any questions, please contact Provider Services at (401) 459-6080. Thank you.