Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

Claims Request Form

All Claim Adjustment Requests/New Claims must be submitted within the 90-day billing period.

TYPE OF REQUEST

☐ Claim Inquiry ☐ Adjustment Request ☐ Void a Claim ☐ Resubmission of Denied Claim

Provider Name: _____ Provider # _____

Member Name: _____ Member ID # _____

Social Security # _____ DOB _____

Service Code _____ **SUBMIT A COPY OF THE RA WITH REQUEST** Claim # or 837 Submission Date | | | | | | | | |

Date of Service From ____/____/____ Billed Amount Paid Amount RA Date

To ____/____/____ $_____ $_____ ____/____/____

Please check (✓) reason for submitting the request

☐ Over Payment ☐ Under payment ☐ Full Recoupment ☐ Other

Please check (✓) changes or corrections to be made

☐ Units/Durations ☐ Billed Amount ☐ Procedure Diagnosis Code ☐ Time Limit Override

☐ Dates of Service ☐ Patient Liability ☐ Further Medical Review ☐ Third Party Liability

☐ Medicare Adjustments ☐ Open Billing ☐ Other

(Attach all related Medicare Vouchers)

Please specify reason for request

Signature of Sender _____ Print Sender Name _____

Position of Sender _____ Date _____

Phone # _____ Fax # _____ Email Address _____

**Note: If your agency uses a third party biller, please ensure that Trillium has a current BAA or QSO on file. If no agreement is on file, then PHI will not be released.*

TRILLIUM INTERNAL USE ONLY

Reviewed and/or Processed by

Date Processed and/or Provider Contacted ____/____/____

Provider Contact: _____

☐ Third Party Biller - Verified BAA/QSO

☐ Stated Funded ☐ Medicaid ☐ Approved ☐ Denied

Please send this form to - Attn: Claims Department, 144 Community College Road, Ahoskie, NC 27910 or Fax to (252) 215-6877 or send via secure email to Claims2@TrilliumNC.org.