encova INSURANCE

ADJUSTMENT/ CORRECTION REQUEST

Instructions for completion appear on reverse side.

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

1. Transaction control number		
2. Provider number (FEIN plus 2-digit location number)	3. Claimant Social Security number	
4. Claimant name (last, first and middle)	5. Claim number	6. Date of injury

ITEMS 7, 8 AND 9 FOR ENCOVA USE ONLY.

7. Credit number	8. Returned warrant number	9. Approved by

10. Correction – complete only those items listed incorrectly or omitted on the remittance advice

Item	As listed on remittance advice	Corrected information
(a) Claim number		
(b) Claimant Social Security number		
(c) Date of injury		
(d) Date(s) of service		
(e) Procedure/drug code		
(f) Units of service		
(g) Line item charge		
(h) Revenue code/rate		
(i) Tooth number		
(j) Provider name		
(k) NPI (national provider identifier)		
(l) Third party payment		
(m) Other (list)		

11. Narrative description for adjustment/correction request

12. As provided by statute, this is to certify that the medication(s) or services were provided or rendered as outlined above and that no other or additional charge for such medication(s), treatment, appliance or device has been or will be made against any person, firm or corporation.	13. Provider name, address and telephone number
Signature	
Date	

USE OF THE ADJUSTMENT / CORRECTION REQUEST FORM

The adjustment/correction request form should be used to correct information listed incorrectly on the remittance advice which resulted in an over- or underpayment OR a denial. This form should NOT be used when the payment or denial was the result of Encova policy regarding the services provided. Only one line item may be corrected on each adjustment/correction request form unless you attach a copy of the original invoice, highlighting each line to be corrected or adjusted.

INSTRUCTIONS FOR COMPLETION OR ADJUSTMENT/CORRECTION REQUEST FORM

1. **TRANSACTION CONTROL NUMBER:** Enter the transaction control number (TCN) assigned to the bill you wish to correct or adjust. This number is found on the remittance advice on which the bill was either denied or mispaid.
2. **PROVIDER NUMBER:** Enter the business federal tax number as it is reported to the Internal Revenue Service, plus the two-digit location number assigned by Encova. This number serves as your provider number.
3. **CLAIMANT'S SOCIAL SECURITY NUMBER:** Enter the claimant's nine-digit Social Security number.
4. **CLAIMANT'S NAME:** Enter the claimant's full name – last, first and middle.
5. **CLAIM NUMBER:** Enter the claim number assigned to the claimant's approved occupational injury or exposure report.
6. **DATE OF INJURY:** Enter the official date of injury or date of last exposure for the compensable condition for which you supplied services.
7. These fields are for internal use ONLY. Please leave blank.
8. These fields are for internal use ONLY. Please leave blank.
9. These fields are for internal use ONLY. Please leave blank.
10. **CORRECTION(S):** Enter a correction to any field listed which resulted in a denial or mispayment. List the item as it was reported on the remittance advice, then list the corrected version in the column directly to the right of the incorrect version. If the item was omitted from the remittance advice, leave the left-hand column blank. Leave blank any field which was reported correctly.
11. **NARRATIVE:** Please explain as briefly as possible the reason you are requesting an adjustment or correction. If absolutely necessary, attach a letter of explanation or copy of the original bill.
12. **SIGNATURE AND DATE:** The provider himself or a legally responsible designee must sign and date the form. Signature stamps are acceptable.
13. **PROVIDER NAME, ADDRESS AND TELEPHONE NUMBER:** Enter your business name and address, with telephone number.

Submit your adjustment/correction request form to the same address as you would original bills.
(See front of form for address.)