Hometown Health

LARGE VOLUME CLAIM ADJUSTMENT REQUEST FORM

Date of Request _____

Provider Name or Group Name _____

Tax ID _____

Group NPI _____

Name of Point of Contact _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

PLEASE PROVIDE THE REASONING AND DETAILS BEHIND FOR YOUR APPEAL OR REQUEST FOR ADJUSTMENT

(Large volume adjustments are considered more than 10 claims.)

PLEASE EMAIL THIS COMPLETED FORM TO **ProviderUpdates@HometownHealth.com**.
PLEASE ENTER "**Large Volume Claim Adjustment Request**" IN THE EMAIL SUBJECT LINE.

Non-participating providers must submit all adjustments within 90 days from the date of explanation of payment.
Participating providers must submit all requests for adjustments within 90 days from the date of explanation of payment unless otherwise outlined in the Provider Agreement.
Provider's failure to submit requests within such time period will result in the request being denied by Hometown Health.
The date this form is received will serve as the submission date for the request of adjustment of claims.