Corewell Health™

PROVIDER ADJUSTMENT (BILLED SERVICES)

Date of request _____ Site requesting _____

Name of person requesting _____ Phone number to reach you at _____

Patient name _____ Account/MRN _____

Date of birth _____ Insurance _____

Date of service _____ CPT/Procedure code(s) _____

Check appropriate box

- ☐ Test do over
- ☐ Service couldn't be completed
- ☐ Duplicate labs conducted at Corewell Health
- ☐ Service repeated due to equipment/power failure
- ☐ Wrong service conducted in error
- ☐ Other _____
- ☐ Service(s) incorrectly ordered
- ☐ Scheduling error
- ☐ Lab/Services done too early
- ☐ Patient billed but never received services

Reason for change/adjustment request or other scenario not listed

Adjustment amount _____

Physician/Provider signature **(required)** _____

Note That We Will Not Accept Physician Signature Stamps

Email This Form To: Customer Service - PLST customerserviceplst@corewellhealth.org

You will be contacted once the request has been reviewed and processed. Form will be scanned into the M drive.

Submit Form