Oregon State Public Health Laboratory

Claim Adjustment Request Form

If you believe there are claims on your invoice that should be billed to another entity or removed from your invoice, please complete the form below and send via secure email to OSPHL@pcgus.com

Please note: If the claim was already properly submitted to Medicaid and denied, it is now the facility's responsibility. Corrected Medicaid information will be accepted if available. For questions, please contact PCG at **1-844-300-5044.**

Location Name _____**Location Number** _____
Adjustment Request Contact_____ **Phone Number**_____

Invoice Number	Chart # (**Required**)	Billing ID **(Required)**	
DOB(MM)LOC(NNN)LASTNAME	Specimen ID	Service Date	Amount
Reason For Adjustment			
Diagnosis Code	CPT Code		
Insurance or Medicaid CCO Plan Name (if applicable)	Member ID		

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Invoice Number	Chart # **(Required)**	Billing ID **(Required)**	
DOB(MM)LOC(NNN)LASTNAME(AAA)	Specimen ID	Service Date	Amount
Reason For Adjustment			
Diagnosis Code	CPT Code		
Insurance or Medicaid CCO Plan Name (if applicable)	Member ID		

Note: Fillable pdf version of this form can be obtain at: www.healthoregon.org/phlbilling Please send an email to OSPHL@pcgus.com if you would like instructions on the PCG Secure Email System