**Large Volume Underpayment Adjustment Request Form**

Date of Request:

Provider Name or Group Name:

Tax ID Number:

NPI:

Address:

Phone Number:

Name of Point of Contact:

Email:

Contractual time frame for Underpayment adjustments based on your Provider Agreement:

Please provide the reasoning and details regarding the adjustment of claims not paid according to the Provider Agreement here:

Please email this completed form to: [providerrelations-hometownhealth@hometownhealth.com](mailto:providerrelations-hometownhealth@hometownhealth.com)

**\**Please note all underpayment adjustment requests must be submitted 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.***