Request for Review of Claim Assessment

Medical Services Branch
3475 Albert Street
Regina SK S4S 6X6
Fax: 306-798-0582
www.ehealthsask.ca

Claim Information: (from paylist) **All fields must be complete**

Patient's Name	Health Services Number (HSN)	Clinic Number	Doctor Number

Date of Service			Claim Number	Run Code	Mode	Surgical Start Time	Surgical End Time	Hospital Care Admit & Discharge Dates
Day	Month	Year						
								A: D:

Doctor's Name:_____ **Phone Number:**_____

Service Code	Explan Code	(MSB Use Only)

Request:
- ☐ **Change date of service:** _____
- ☐ **Billed in error; please retract:** _____
- ☐ **Other:**

Date:_____ **Signature:** _____

Medical Services Branch Reply:
- ☐ **No change to original assessment**
- ☐ **This claim was paid in run:** _____ **New Claim #:**_____
- ☐ **This claim will be processed for payment in:** **Run:**____ **Claim#:**_____

If you have any questions regarding this adjudication, please contact our Claims Analysis unit at: (306)787-3454. Thank you. **Date:**_____

Saskatchewan