Government of Saskatchewan

**Medical Services Branch**
3475 Albert Street
Regina SK S4S 6T7
Fax: 306-798-0582
www.saskatchewan.ca

# Request for Review of Claim Assessment

**Claim Information: All fields must be complete**

| Patient's Name | Health Services Number (HSN) | Date of Service | | |
|---|---|---|---|---|
| | | Day | Month | Year |
| | | | | |

| Claim Number | Run Code | Mode | Clinic Number | Doctor Number | Surgical Start Time | Surgical Stop Time | Hospital Care Admit & Discharge Dates: | ☐ Team Surgery Dr.________ Dr.________ |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | A: D: | *Must include all operative reports for adjudication* |

**Doctor's Name:**________________________ **Phone No:** ____________________

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

**Date:**________________ **Signature:**________________________

**Please include all service codes billed below:**

| Service Code | Explan Code | (Shaded area MSB use only) |
|---|---|---|
| | | |
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**Medical Services Branch Reply:** ☐ **No change or original assessment**
☐ **Adjusted as follows** **Date Sent:**________________

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