**HEALTHCARE ADJUSTMENTS WORKSHEET**

**PROVIDER NAME:** _____ **COMPANY NO:** _____ **GROUP NO.** _____

**ADJUSTMENTS REQUIRED TO CORRECT BES RECORDS** **MONTH OF:** _____

| | | | ***ADDITIONAL PREMIUMS DUE (ADD TO BILL AMOUNT)*** | | ***REDUCTION OF PREMIUMS DUE (DELETE FROM BILL AMOUNT)*** | | |
|---|---|---|---|---|---|---|---|
| ***EE No*** | ***EMPLOYEE NAME*** | ***EFF DATE*** | ***PLAN*** | ***AMOUNT*** | ***PLAN*** | ***AMOUNT*** | ***COMMENTS/ACTION*** |
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