

MEDICAID ADJUSTMENT

MAIL TO:
EDS ADJUSTMENT UNIT
P O BOX 300009
RALEIGH, NC 27622

Provider Number: _____

Provider Name: _____

Recipient Name: _____ Recipient ID: _____

Date of Service: From: / / to / / Claim Number: _____

Please Check (): Billed Amount: Paid Amount: RA Date:
_____ Overpayment _____

NOTE: **THIS FORM IS FOR CLAIM ADJUSTMENT ONLY.**

_____ Underpayment A CORRECTED CLAIM AND RA MUST BE ATTACHED.

_____ Full Recoupment

_____ Other

CLAIM INQUIRIES (i.e., time limit overrides) WILL NOT BE PROCESSED FROM THIS FORM

Please Check () changes or corrections to be made:

_____ Units _____ Procedure/Diagnosis Code _____ Billed Amount
_____ Dates of Service _____ Patient Liability _____ Further Medical Review
_____ Third Party Liability _____ Medicare Adjustments

Please Specify Reason for Adjustment Request:

Signature of Sender: _____ Date: _____ Phone #: _____

TO BE USED BY EDS ONLY

Remarks:

MEDICAID RESOLUTION INQUIRY

MAIL TO:
EDS PROVIDER SERVICES
P O BOX 300009
RALEIGH, NC 27622

Please Check: Claim Inquiry Time Limit Override

NOTE: PLEASE USE THIS FORM FOR **TIME OVERRIDES AND INQUIRIES ONLY.**
CLAIM, RAs, AND ALL RELATED INFORMATION MUST BE ATTACHED.
ADJUSTMENTS WILL NOT BE PROCESSED FROM THIS FORM.

Provider Number: _____

Provider Name and Address: _____

Patient's Name: _____ Recipient ID: _____

Date of Service: From: / / to / / Claim Number: _____

Billed Amount: _____ Paid Amount: _____ RA Date: _____

Please Specify Reason for Inquiry Request:

Signature of Sender:

Date:

Phone #:

TO BE USED BY EDS ONLY

Remarks:

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
PROVIDER CERTIFICATION
FOR
SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

SIGNATURE:

Print or Type Business Name of Provider

Signature of Provider

Date

Group provider number to which this certification applies: _____

Attending provider number to which this certification applies: _____

Return completed form to: EDS
 Provider Enrollment
 P.O. Box 300009
 Raleigh, NC 27622

Special W-9

Complete all four parts below and return to EDS. Incomplete forms will be returned to you for proper completion.

Provider Name:

Provider Number:

Part I. Provider Taxpayer Identification Number:

Your tax identification number should be reflected below exactly as the IRS has on file for you and/or your business. Please verify the number on file (per the last page of your most recent RA) and update as necessary in the correction fields listed below:

Correction Field (please write clearly in black ink):

Employer Identification Number/Taxpayer Identification Number

Social Security Number **If you do not have an employer ID then indicate social security number if you are an individual or sole proprietor only

Part II. Provider Tax Name:

Your tax name should be reflected below exactly as the IRS has on file for you and/or your business. Individuals and sole proprietors must use their proper personal names as their tax name. Please verify the name on file (per the last page of your most recent RA) and update as necessary in the correction fields listed below:

Correction Field:

Part III. Type of Organization - Indicate below:

___ Corporation/Professional Association ___ Individual/Sole Proprietor ___ Partnership

___ Other: _____ ___ Government: _____

Part IV. Certification

Certification - Under the penalties of perjury, I certify that the information provided on this form is true, correct, and complete.

Signature Title Date

EDS Office Use Only Date Received: _____ Name Control: _____ Date Entered: _____
