MEDICAID CLAIM ADJUSTMENT REQUEST

(This form is not to be used for claim inquiries or time limit overrides.)

PLEASE COMPLETE THIS FORM IN BLUE OR BLACK INK ONLY

MAIL TO:
HP ENTERPRISE SERVICES
ADJUSTMENT UNIT
PO BOX 300009
RALEIGH, NC 27622

A CORRECTED CLAIM

AND THE APPROPRIATE RA MUST BE ATTACHED

HP Enterprise Services USE ONLY

One Step: _____

Provider #:_____ Provider Name:_____

Recipient Name:_____ MID#:_____

SUBMIT A COPY OF THE RA WITH REQUEST

Claim #: | | | | | | | | | | | | | | | | | | | |

Date Of Service: From:_____/_____/_____ To: _____/_____/_____

Billed Amount: $_____

Paid Amount: $_____

RA Date: _____/_____/_____

Please check (\) reason for submitting the adjustment request:

- ☐ Over Payment
- ☐ Under Payment
- ☐ Full Recoupment
- ☐ Other

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 (Attach all related Medicare Vouchers)
- ☐ Other

HP Enterprise Services USE ONLY

Do not write in this block

Please Specify Reason for Adjustment Request:

Signature Of Sender:

Date: / /

Phone #: ( ) -

HP Enterprise Services INTERNAL USE ONLY

Clerk ID#:_____Sent to:_____ Date sent:_____/_____/_____

Reason for review:_____

Reviewed by:_____ Date reviewed:_____/_____/_____

Outcome of review:_____

Date received back in the Adjustment Department: _____/_____/_____

Revised 2/15/10