

**CMS - 1500, DENTAL, CROSSOVER PART B PAID CLAIM ADJUSTMENT REQUEST
INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION**

Mail completed requests to: HP - Adjustments, P.O. Box 7265, Indianapolis, IN 46207-7265

(1) PROVIDER NPI or LPI and Service Location: PROVIDER NAME/ADDRESS/ZIP+4: Taxonomy Code: PHONE NUMBER: CONTACT PERSON:		(2) REASON FOR ADJUSTMENT: (Check appropriate Box) <input type="checkbox"/> Change TPL Amt. <input type="checkbox"/> Change Patient Deductible Amt. <input type="checkbox"/> Offset or Refund of entire claim amount (Please check block 11) <input type="checkbox"/> Change information as indicated in blocks 14-18 <input type="checkbox"/> Medicare Adjustment (Attach all EOMBs that apply to this adjustment)	
(3) CLAIM NUMBER (ICN)	(4) MEMBER ID NO.	(5) DATE OF SERVICE From Thru	(6) Referring NPI/Taxonomy
(7) MEMBER NAME	(8) AMOUNT PAID	(9) REMITTANCE ADVICE DATE	
(10) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST:			

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(11) TYPE OF ADJUSTMENT <input type="checkbox"/> Underpayment Adjustment <input type="checkbox"/> Overpayment Adjustment (Deduct from future payments) <input type="checkbox"/> Refund Adjustment (Check attached) Check number:	(12) CLAIM TYPE <input type="checkbox"/> CMS - 1500 <input type="checkbox"/> Dental <input type="checkbox"/> Crossover	(13) PROGRAM <input type="checkbox"/> Medicaid <input type="checkbox"/> CSHCS <input type="checkbox"/> ARCH <input type="checkbox"/> 590
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PLEASE LIST THE INFORMATION TO BE CORRECTED IN THE BLOCKS BELOW. IF NO LINE NO. IS ASSOCIATED WITH THE CORRECTION, PLEASE ENTER A ZERO (0) IN THE LINE NUMBER FIELD. FOR EXAMPLE, TPL APPLIED WOULD ALWAYS BE LINE # 0.

(14) LINE NO.	(15) DESCRIPTION OF INFORMATION TO BE CORRECTED	(16) CURRENT INFORMATION	(17) CORRECTED INFORMATION	(18) Rendering NPI and Taxonomy Code

(19) SIGNATURE: _____ **(20) DATE:** _____

A completed adjustment request form is required for each claim adjustment request. In addition, a copy of the RA and a copy of the corrected claim will help facilitate the adjustment process, but these are not required documents. If the adjustment request is for a crossover claim, please attach a copy of the Medicare EOMB. If the request is for an adjustment to the spenddown deductible amount, please attach a copy of the 8A form.

1. PROVIDER NUMBER Enter the nine-digit billing provider number and the one-character service location or a ten-digit billing NPI number.
- PROVIDER NAME/ADDRESS Enter the current billing name, address, ZIP Code+4, and taxonomy code.
- CONTACT PERSON Enter a contact name.
- PHONE NUMBER Enter a current phone number.
2. REASON FOR ADJUSTMENT Check the appropriate box for the reason of the adjustment request.
3. CLAIM NUMBER (ICN) Enter the ICN of the claim to be adjusted. This can be found on the RA. Please use the most current ICN for the claim to be adjusted.
4. MEMBER ID NO. Enter the member's 12-digit identification number (RID).
5. DATE OF SERVICE Enter the From and Thru Dates of Service as billed on the claim.
6. Referring NPI/Taxonomy Enter the Referring provider NPI and taxonomy.
If the claim was submitted prior to the NPI implementation with a Referring LPI, the NPI/Taxonomy is required for all health care claims.
7. MEMBER NAME Enter the First and Last Name of the member.
8. AMOUNT PAID Enter the Paid Amount of the claim to be adjusted.
9. REMITTANCE ADVICE DATE Enter the date of the RA on which the claim last paid.
10. EXPLANATION Give a clear explanation for the requested adjustment or refund.
11. TYPE OF ADJUSTMENT Check the appropriate box for the type of adjustment being requested:
Underpayment – An adjustment to a claim requesting an additional payment, or requesting a change to the claim's data which will result in no net change in payment.
Overpayment – An adjustment to a claim requesting that an overpaid amount be deducted from future payments. This can be a recoupment of a portion of the claim or the entire amount of the claim.
Refund – Same as overpayment except that a refund check or the overpaid amount is being submitted. A refund can be applied to a portion of the claim or to the entire amount of the claim.
12. CLAIM TYPE Check the appropriate box of the claim type to be adjusted.
13. PROGRAM Check the appropriate box of the program the claim is associated with.
14. LINE NO. Enter the line number of the data to be adjusted. If adjusted data is not associated with a specific line on the claim, enter a zero in this field.
15. DESCRIPTION Enter a brief description of the data that is to be corrected on the claim.
16. CURRENT INFO Enter the information as stated on the current claim that is to be adjusted.
17. CORRECTED INFO Enter the corrected information for the claim.
18. Rendering NPI/Taxonomy Enter Rendering provider NPI and Taxonomy.
If the claim was submitted prior to the NPI implementation with a Rendering LPI, the NPI/Taxonomy is required for all health care claims.
19. SIGNATURE Enter the signature of an appropriate person such as a physician or billing clerk.
20. DATE Enter the date the request is submitted.