



P O S R E V E R S A L V O I D R E Q U E S T

FAX TO: (317) 488-5100

1. NPI Number:			
2. Provider Name:		Provider Address:	
3. Reason for Reversal: (Check appropriate Box)			
<input type="checkbox"/> Reversal Not Processed		<input type="checkbox"/> Reversed in Pharmacy system but not HP	
<input type="checkbox"/> Paid claim not viewable in Pharmacy system		<input type="checkbox"/> Pharmacy unable to reverse Paid claim	
4. Telephone Number:		5. Contact Person:	
6. Member ID Number:		7. Member's Name (Last, First):	
8. Claim Number (ICN):		9. Date of Service:	10. Amount Submitted:
11. NDC:		12. Rx Number:	
13. Claim Type: <input type="checkbox"/> Pharmacy <input type="checkbox"/> Compound			
14. Complete Explanation of the Void Request:			
15. Type Of Void: <input type="checkbox"/> Complete Reversal			
COMPLETE BLOCKS 1 – 17 FOR EACH PHARMACY CLAIM TO BE VOIDED. IF ALL INFORMATION IS NOT COMPLETE, THIS REQUEST WILL BE RETURNED.			
16. SIGNATURE:		17. DATE:	

A completed reversal request form is required for each claim reversal request.

1. NPI NUMBER Enter the ten-digit billing provider's NPI.
2. PROVIDER NAME/ADDRESS Enter the current billing name and address.
3. REASON FOR REVERSAL Check the appropriate box for the reason of the reversal request.
4. TELEPHONE NUMBER Enter a current phone number.
5. CONTACT PERSON Enter a contact name.
6. MEMBER ID NO. Enter the member's 12-digit identification number (RID).
7. MEMBERS NAME Enter the last name, first name of the member.
8. 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 voided.
9. DATE OF SERVICE Enter the From and Thru Dates of Service as billed on the claim.
10. AMOUNT SUBMITTED Enter the Submitted Amount of the claim to be voided.
11. NDC Enter the National Drug Code (NDC) submitted on the claim to be voided.
12. RX NUMBER Enter the Prescription number submitted on the claim to be voided.
13. CLAIM TYPE Check the appropriate box of the claim type for the void request.
14. EXPLANATION OF VOID REQUEST Give a clear explanation for the requested void.
15. TYPE OF VOID Check the appropriate box for the void request.
16. SIGNATURE Enter the signature of an appropriate person such as a physician or billing clerk.
17. DATE Enter the date the request is submitted.