| Hospice Providers Only

Accounts Receivable Refund Adjustment

www.indianamedicaid.com

1. Provider Number:			
2. Provider Name and Address:		3. Provider Phone Number:	4. Contact Name:
5. Reason for Adjustment: Hospice Overpaid Claims	6. Claim Number (ICN):	7. Recipient ID Number:	8. Date of Service:
9. Recipient Name:		10. Amount Paid:	
11. Type of Adjustment. Hospice Refund Adjustment (Check Attached): Check Number: Amount:			
12. Claim Type: Home Health		13. Program: Medicaid	
14. Give Complete Explanation of Adjustment or Refund Request: Refund for Revenue Code 653 or 654, billed on a Home Health Claim, when commercial insurance has made a payment towards the hospice care services.			

Please provide the calculations needed to confirm overpayment in the boxes provided below (examples can be found in Tables 3 and 4 of the April 2007 Provider Newsletter NL200704).	
15. Nursing Home Room and Board Level of Care Calculation	16. Hospice Routine Home Care Calculation
17. Signature:	18. Date:
Note: All fields are required to complete the request. If any information is missing, there will be a delay in processing the request.	

Mail the completed request to:

HP
P.O. Box 2303 Dept. 130
Indianapolis, IN 46206-2303