| Hospice Providers Only

IHCP Hospice Accounts Receivable Refund Adjustment

indianamedicaid.com

This form is only for overpayments on hospice claims submitted before **February 13, 2017**.

1. National Provider Identifier/IHCP Provider ID:			
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:		13. Program: Medicaid	
14. Give complete explanation of adjustment or refund request:			

Please provide the calculations needed to confirm overpayment in the boxes below (for examples, see the Nursing Facility Room-and-Board Calculation Table in the *Hospice Services* provider reference module).

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. Missing information will delay the processing of the request.

Mail the completed request to the Indiana Health Coverage Programs (IHCP) at:
DXC Refunds
P.O. Box 2303, Dept. 130
Indianapolis, IN 46206-2303