

Mail to: EDS
PO Box 23
Boise, ID 83707

Do not fax this form

Information: (800) 685-3757

Adjustment Request Form

1. Provider Medicaid Number: _____

4. Claim ICN: _____

2. Prov. Name: _____

5. Client Medicaid Number: _____

3. Prov. Address: _____
_____ ZIP _____

6. Client Name: _____

7. RA Number: _____

8. RA Date: _____

9. Correct Billing Information:

Claim Line (optional)	Incorrect information on claim	Correct information for adjustment

10. Requested Action:

- I am refunding the overpayment (attach check made out to: **State of Idaho**).
- Please withhold overpayment in a future Medicaid warrant with an adjustment.
- Please pay me more in a future warrant due to an underpayment by Medicaid.

11. Signature: _____

Date: _____

EDS use only	Related History ICN: _____
Action: _____	

Adjustment Request Form Instructions

This Adjustment Request Form can be duplicated for use as needed. When making copies, it is not necessary to copy these instructions also. Adjustment requests must be mailed. Please do **not** fax this form.

1. **Provider Medicaid Number:** enter your 9-digit Medicaid provider identification number. Do **not** use a Social Security or FEIN number. This number is in the upper left-hand corner of the first page of your remittance advice (RA).
2. **Prov. Name:** enter your provider name. This is in the lower right-hand corner of the first page of your RA.
3. **Prov. Address:** enter your mailing address. This is in the lower right-hand corner of the first page of your RA.
4. **Claim ICN:** This is the unique 15-digit claim identification number. It is found on the Paid Claim page of your RA following the client's MID.
5. **Client Medicaid Number (MID):** enter the 7-digit client Medicaid Identification Number. It is found on the Paid Claim page of your RA following the client's name. Do not use a Social Security number.
6. **Client Name:** enter the client's name as it is on the RA. It is found on the Paid Claim page of your RA.
7. **RA Number:** This is in the upper right-hand corner of the first page of your RA.
8. **RA Date:** enter the date from the RA. This is at the top of the first page of your RA.
9. **Correct Billing Information:** simply and clearly state what the correct billing information should have been on the claim. If a line of a claim needs to be corrected, enter the line number from the claim form. Enter what was wrong on the line and the correct information to replace it.

Example: a claim is incorrectly billed with 100 units on line 4 and, after the claim is submitted, the provider receives a check from other insurance. The correct number of units is 10 and the insurance amount is \$1124.47. Complete the form as shown:

Claim Line (optional)	Incorrect information on claim	Correct information for adjustment
4	100 units billed	Correct number of units is 10
		Other insurance paid \$1124.47

10. **Requested Action:** select the appropriate box. If you owe a refund to Medicaid because of an overpayment, you can send a check for the amount or request that the overpayment be deducted from future warrants. Make checks payable to: **State of Idaho**.
11. **Signature:** the person who completes this form must sign and date it.

Adjustments may be initiated by:

- Providers to correct claims submission or processing errors
- EDS to recoup incorrect payments
- DHW for recoupments or retroactive rate adjustments

Adjusted claims are grouped together in the RA by provider service location. Each service location has a separate section. Within provider service location, the adjusted claims are sorted by client last name. Grand totals are calculated for adjustment claim totals and a total net adjustment amount is calculated to reflect the net effect of all adjustments.