

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

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

(1) PROVIDER NUMBER: PROVIDER NAME/ADDRESS: 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 10) <input type="checkbox"/> Change information as indicated in blocks 13-16 <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) MEMBER NAME		(7) AMOUNT PAID	(8) REMITTANCE ADVICE DATE
(9) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST: 			
(10) TYPE OF ADJUSTMENT		(11) CLAIM TYPE	(12) PROGRAM
<input type="checkbox"/> Underpayment Adjustment <input type="checkbox"/> Overpayment Adjustment (Deduct from future payments) <input type="checkbox"/> Refund Adjustment (Check attached) Check number: _____		<input type="checkbox"/> CMS - 1500 <input type="checkbox"/> Dental <input type="checkbox"/> Crossover	<input type="checkbox"/> Medicaid <input type="checkbox"/> CSHCS <input type="checkbox"/> ARCH <input type="checkbox"/> 590
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.			
(13) LINE NO.	(14) DESCRIPTION OF INFORMATION TO BE CORRECTED	(15) CURRENT INFORMATION	(16) CORRECTED INFORMATION

(17) SIGNATURE: _____ **(18) 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. |
| | PROVIDER NAME/ADDRESS | Enter the current billing name and address. |
| | 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. | MEMBER NAME | Enter the First and Last Name of the member. |
| 7. | AMOUNT PAID | Enter the Paid Amount of the claim to be adjusted. |
| 8. | REMITTANCE ADVICE DATE | Enter the date of the RA on which the claim last paid. |
| 9. | EXPLANATION | Give a clear explanation for the requested adjustment or refund. |
| 10. | 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. |
| 11. | CLAIM TYPE | Check the appropriate box of the claim type to be adjusted. |
| 12. | PROGRAM | Check the appropriate box of the program the claim is associated with. |
| 13. | 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. |
| 14. | DESCRIPTION | Enter a brief description of the data that is to be corrected on the claim. |
| 15. | CURRENT INFO | Enter the information as stated on the current claim that is to be adjusted. |
| 16. | CORRECTED INFO | Enter the corrected information for the claim. |
| 17. | SIGNATURE | Enter the signature of an appropriate person such as a physician or billing clerk. |
| 18. | DATE | Enter the date the request is submitted. |