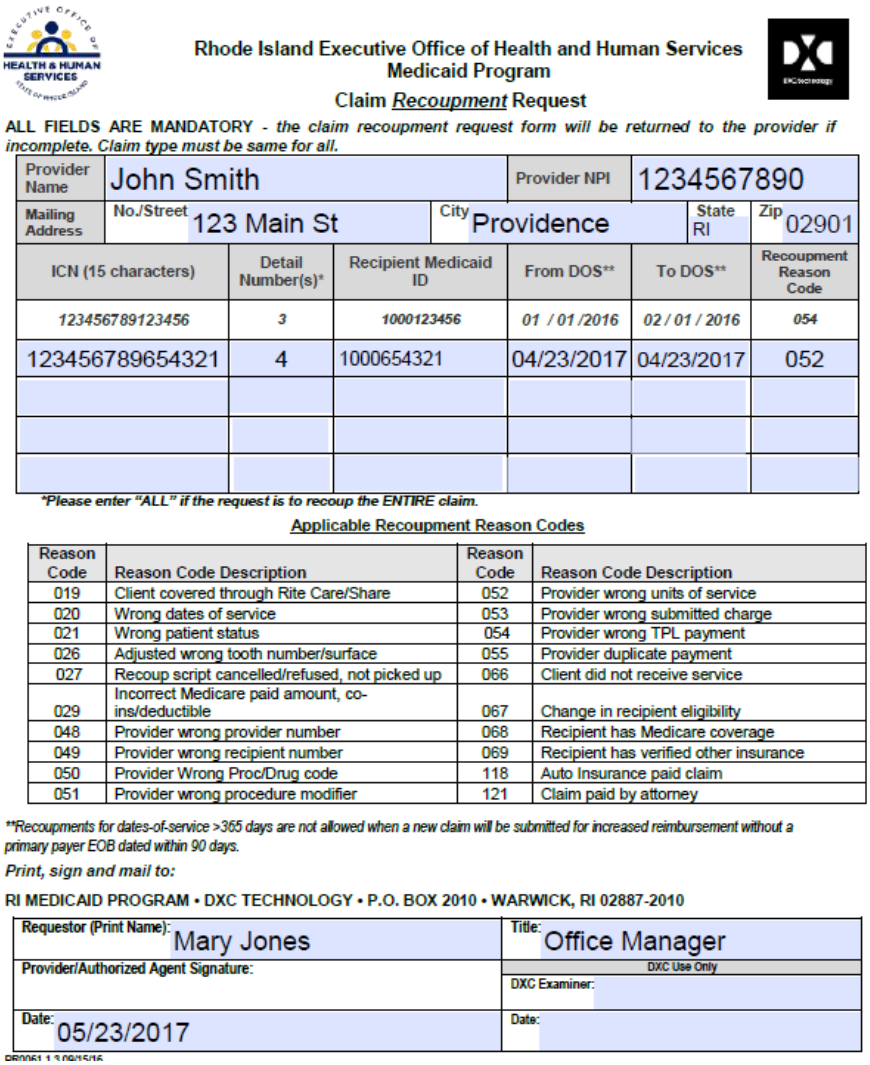
Fillable Recoupment Request Form

A fillable form contains fields that you can complete on your computer, once you open the document. The blue shaded area indicates a fillable field.



Rhode Island Executive Office of Health and Human Services
Medicaid Program
Claim *Recoupment* Request

ALL FIELDS ARE MANDATORY - *the claim recoupment request form will be returned to the provider if incomplete. Claim type must be same for all.*

Provider Name	John Smith			Provider NPI	1234567890
Mailing Address	No./Street 123 Main St	City Providence	State RI	Zip 02901	

ICN (15 characters)	Detail Number(s)*	Recipient Medicaid ID	From DOS**	To DOS**	Recoupment Reason Code
123456789123456	*3*	*1000123456*	*01 / 01 /2016*	*02 / 01 / 2016*	*054*
123456789654321	4	1000654321	04/23/2017	04/23/2017	052

**Please enter "ALL" if the request is to recoup the ENTIRE claim.*

Applicable Recoupment Reason Codes

Reason Code	Reason Code Description	Reason Code	Reason Code Description
019	Client covered through Rite Care/Share	052	Provider wrong units of service
020	Wrong dates of service	053	Provider wrong submitted charge
021	Wrong patient status	054	Provider wrong TPL payment
026	Adjusted wrong tooth number/surface	055	Provider duplicate payment
027	Recoup script cancelled/refused, not picked up	066	Client did not receive service
029	Incorrect Medicare paid amount, co-ins/deductible	067	Change in recipient eligibility
048	Provider wrong provider number	068	Recipient has Medicare coverage
049	Provider wrong recipient number	069	Recipient has verified other insurance
050	Provider Wrong Proc/Drug code	118	Auto Insurance paid claim
051	Provider wrong procedure modifier	121	Claim paid by attorney

***Recoupments for dates-of-service >365 days are not allowed when a new claim will be submitted for increased reimbursement without a primary payer EOB dated within 90 days.*

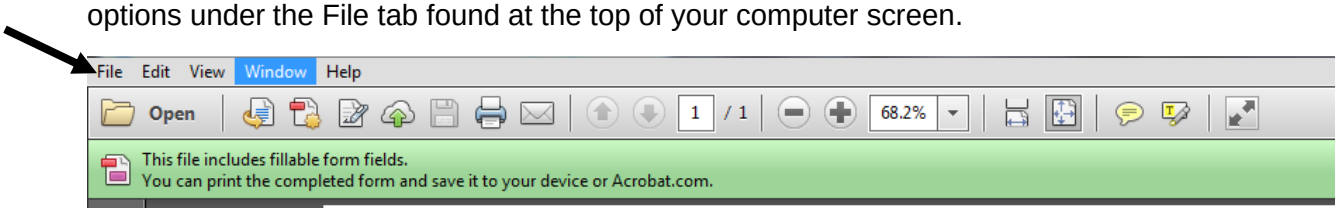
Print, sign and mail to:

RI MEDICAID PROGRAM • DXC TECHNOLOGY • P.O. BOX 2010 • WARWICK, RI 02887-2010

Requestor (Print Name): Mary Jones	Title: Office Manager
Provider/Authorized Agent Signature:	DXC Use Only DXC Examiner:
Date: 05/23/2017	Date:

PR0061 1.3 09/15/16

Once the document is completed, you can save to your computer before printing, by using the options under the File tab found at the top of your computer screen.



Forms must contain an original signature and be mailed to:

DXC Technology
PO Box 2010
Warwick, RI 02887