

OFFICE OF HEALTH AND HUMAN SERVICES
 MEDICAL ASSISTANCE PROGRAM
MULTIPLE ADJUSTMENT / RECOUP REQUEST FORM

1. PROVIDER NAME

2. MEDICAL ASSISTANCE PROVIDER NUMBER

3. PLEASE SPECIFY REASON FOR ADJUSTMENT BY CHECKING THE APPROPRIATE CHOICE (CLAIM TYPE AND REASON MUST BE SAME FOR ALL ATTACHED)

ADJUSTMENTS

- CHANGE IN AMOUNT OF TPL PAYMENT
- INCORRECT DATES OF SERVICE
- INCORRECT SUBMITTED CHARGES
- INCORRECT UNITS OF SERVICE
- INCORRECT PROCEDURE/DRUG CODE
- INCORRECT PROCEDURE MODIFIER
- OTHER

RECOUPS

- CLIENT DID NOT RECEIVE SERVICES
- DUPLICATE PAYMENT
- INCORRECT PROVIDER NUMBER
- CHANGE IN RECIPIENT ELIGIBILITY
- INCORRECT RECIPIENT NUMBER
- RECIPIENT HAS OTHER PRIMARY INSURANCE

ADDITIONAL INFORMATION, IF NECESSARY:

4. AMOUNT	5. CLAIM INTERNAL CONTROL NUMBER	6. DE-TAIL NO	7. FROM DOS	8. TO DOS	9. RA DATE	10. RECIPIENT NAME	11. RECIPIENT MEDICAL ASSISTANCE NUMBER
0							
1							
2							
3							
4							
5							
6							
7							
8							
9							

IMPORTANT: THIS ADJUSTMENT / RECOUP WILL NOT BE PROCESSED UNLESS THIS FORM IS COMPLETED

12. PLEASE PRINT CONTACT NAME

13. CONTACT PHONE NUMBER

14. SIGNATURE

15. DATE

**** HP USE ONLY ****

EXAMINER

DATE

FUNDING SOURCE:

**MAIL TO: HP ADJUSTMENTS
 P.O. BOX 2010
 WARWICK, RI 02887-2010**

**Claims can be replaced and voided electronically if submitted within one calendar year. This makes corrections and resubmissions quick and easy. Please contact your provider representative for more information.