MARYLAND MEDICAL ASSISTANCE PROGRAM
MULTIPLE CLAIM
ADJUSTMENT REQUEST FORM

Provider Name:_____ **Provider No.** _____

Address:_____

Tel. No._____ **Total Check Amt.** _____ **Check No.** _____ **Check Date** _____

Adjustment Reason Codes:

1. Incorrect Procedure
2. Incorrect Units of Service
3. Incorrect Modifier
4. Incorrect $ Amt. Charged
5. Wrong Provider Paid
6. Duplicate Payment
7. Other Insurance Paid
8. Outpatient Adm. Hos.
09. Recovery from Attorney
11. TPL Payment Wrong
12. Recipient did not Receive Services
13. Change in Recipient Eligibility
14. Change in Patient Resource

BR Change In Preauthorization

CG Incorrect Date of Service

Invoice Control Number	Recipient I.D. Number	Date of Service	Adj. Rsn Code	Refund $ Amt
1.				
2.				
3.				
4.				
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18.				
19.				
20.				
Name of Provider Representative:	**Date:**	**ICN:**		

DHMH 4567A 10/00 This form is to be sent to the Adjustment Section, Medical Care Program Adm., P.O. Box 13045. Baltimore. MD 21203 410-767-5346