Maryland
DEPARTMENT OF HEALTH

MARYLAND MEDICAL ASSISTANCE PROGRAM
ADJUSTMENT REQUEST FORM

|__Remittance Advice MUST Be Attached__|

1. Provider Name Provider # Provider Address (Street or Box No.) (City. State. ZIP Code)	2. Check One: O Initial Request O Follow-up Request	3. If One Check Enclosed Check No. Check Amt. O More Than One (1) Check Enclosed	4. Claim Type O Home Health O HCFA 1500 O Pharmacy O Vision O Dental O Nursing Home O UB92 O Other
	5. Number of Claims: (this form) Total Number of Claims:	6. Check One: O Medicaid O Medicare Crossover	

7.A. Invoice Control #	B. Date of Service	C. Check One: If Provider Underpaid _____ If Provider Overpaid_______	D. Adjust Reason Code:	E. Complete One: Amount Due Prov. Amount Due State	F. Enter the Corrected Proc. Code, Units, Modifier, S Amt., TPL $ Ami., Recipient #, Resource $ Amt., or Prov. #:
G. Recipient Name (Last, First)	H. Recipient I.D. #	I. Prior Authorization #: (If applicable)	J. Check Amount $	K. Check #: (if enclosed)	

8.A. Invoice Control #	B. Date of Service	C. Check One: If Provider Underpaid If Provider Overpaid	D. Adjust Reason Code:	E. Complete One: Amount Due Prov. Amount Due State	F. Enter the Corrected Proc. Code, Units, Modifier, $ Amt. TPL $ Amt., Recipient #, Resource $ Amt., or Prov. #:
G. Recipient Name (Last, First)	H. Recipient I.D. #	1. Prior Authorization #: (If applicable)	J. Check Amount $	K. Check #:(if enclosed)	

Adjustment Reason Codes *		REMARKS:
01 Incorrect Procedure	08 Outpatient Adm. Hospital	
02 Incorrect Units of Service	79 TPL Payment Wrong **	
03 Incorrect Modifier	80 Recip. Did Not Receive Service	
04 Incorrect $ Amount Charged	83 Change in Recip. Eligibility	
05 Wrong Provider Paid	87 Change in Patient Resource **	
06 Duplicate Payment	BN Pt. Assess. Unbilled Verified **	
07 Other Insurance Paid **	CG Incorrect Date Of Service	
* If uncertain, leave Section D Blank *• Additional Documentation Required (See Instructions on Back)		Name of MCOA Representative/Section: Telephone No: Date:

INSTRUCTIONS FOR COMPLETING THE ADJUSTMENT REQUEST FORM (ARF)

1 Provider Name - Enter the name of the provider who actually received '.he Medicaid payment.

Provider Number - Enter the nine (Q) digit State Medicaid Provider number assigned to the individual provider who received the Medicaid payment.

Provider Address • Enter the complete mailing address: including city, state, and ZIP code of the provider who received the Medicaid payment.

2. Chock One - All adjustment requests on each DHMH 45i8 must bean initial request. follow-up request.

Initial Request - Check "initial request" if a DHMH ^51S has not previously been submitted for the payment(s) in question.

Follow-up Request - If a request has been previously submitted check the "follow-up request" block in red on a photostatic copy *of* the original DHM H 4518. Do not complete a second DHMH *45*18.

3. If One Cheek Enclosed - Complete this block when reimbursing DHMH if only one check is submitted. One check may be used to cover more than one adjustment, provided all of them are included in the same submission. If the check covers paid services for more than one patient, complete items affected showing the amounts refunded for each recipient.

Check Number- Enter the number of the check enclosed

Check Amount - Enter the total dollar amount of the check enclosed.

More Than One Check Enclosed - Complete this block if separate checks are enclosed for each recipient. Enter the check amounts for each recipient in Claim I.D. Fields 7 and 8. Do not enter any check numbers.

4. Claim Type- Indicate the type of claim originally submitted If adjustments are to be requested tor more than one type of claim, separate request forms must be submitted.

5. Total Number of Claims- Enter the number of claims submitted on this form. If the total number of claims exceeds (2). additional request forms must be submitted with the total number of claims involved entered on each form. Example: A request for 18 claims adjustments would require (9) forms and the number 18 would be entered in the total number of claims line on each form.

NOTE: If more than one ARF is used, complete Page _of_ m the upper right comer of the form.

6. Check One - Check the appropriate block to indicate whether the request involves cither Medicaid *or* Medicare Crossover Claims. Do not include both types on the same submission.

INDIVIDUAL CLAIM INFORMATION

For HCFA 1500, Vision, Home Health, and Dental Claims - each individual line item on the form is considered a claim. If, for example, a document has three line items for payment, and line one was paid correctly but lines two and three were not, then line two and three should be reported on the Adjustment Request Form.

For UB92 and Nursing Home Claims, the whole document is considered a claim.

7 A. Invoice Control » - Enter the Invoice Control Number in question as it appears on the remittance advice.

B. Date of Service Enter the six (6) digit date of service (MMDDYY) in chronological order (first to last) Enter all six characters consecutively without dashes. slashes or spaces, example: 020698= February 6, 1998.

C. Check One - Underpaid - If the claim in question results in the provider being underpaid (less than what the Program allows;

Overpaid - If the claim in question results in overpayment by either incorrect billing by the Provider, other insurance has paid for the claim, or the Provider received payment for the duplicate claim, etc. and reimbursement is due the State.

D Adjust Reason Code - Mark the reason for the underpayment or overpayment. A listing for the most prevalent reasons arc found on the front lower left comer of the DHMH 4518.

E. Enter the total $ amount due either the Provider (if underpaid) or State (if overpaid).

F. If the original code, units, modifier, or S amount charged was incorrect, enter the correct information.

G. Recipient Name - Enter the name of the Recipient (last name first) who actually received the service.

H. Recipient I.D.3 - Enter the eleven (11) digit Recipient I.D. #

1. Prior Authorization - Complete only if prior authorization was required for the services billed. Enter the prior authorization number assigned for the service.

J. Check Amount - If more than one check is enclosed, enter the total amount applicable to the specific Recipient

K Check Number - if more than one check is enclosed, enter the check number applicable to the specific Recipient

Adjustment Reason Codes

This is the list of the most prevalent reasons for which an adjustment can be made. If uncertain as to the reason for the payment error, leave Section D blank.

NOTE: Before assigning an Adjustment Reason for a claim, review the remittance advice to ensure the procedure code, modifier, units of service and dollar amount charge is reported accurately.

Additional documentation required for the following Reason Codes:

"07" Explanation of Benefits from Third Party
"79" Explanation of Benefits from Third Party
"87"Copyo206N/C
"BN" Adjustment Transaction Summary

REMARKS

Complete this section to further explain '•other" reasons for an adjustment, such as: Refund if appropriate, requests for the additional payments, or further clarification of the error to be corrected may also be included in this section.

Name of Provider Representative, Telephone Number, Date

Print the name of the Provider Representative responsible for completing the form. Enter telephone number and the date the form was completed.

Billing Time Limitation for Adjustment Requests

The same billing time limitation applies to Adjustment Requests as in initial submission of claims.

REMITTANCE ADVICE MUST BE ATTACHED