

Adjustment Requests

Provider Fair
May 2014



MONTANA DPHHS Public Health and Human Services
Healthy People. Healthy Communities.

Welcome to the Montana Department of Public Health and Human Services
Richard H. Opper, Director

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You must use Medicaid claim after that date

See the April 2013 billing with the new rules. You may also visit [www.mtmedicaid.org](#)

2014 Spring Meeting
Plan to attend the meeting on May 20-21, 2014. For information on updated information, visit [www.mtmedicaid.org](#)

Retroactive Effective January 1, 2014

Forms

Forms are listed alphabetically by form name.

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Forms A-C (09/2013)

- [Abortion Form \(09/2013\)](#)
- [Address Correction Form \(03/2013\)](#)
Physical address change must be accompanied by a completed W-9 form.
- [Adjustment Request Form \(03/2013\)](#)**
- [Ambulance Trip Log \(01/2008\)](#)
- [Attachment Cover Sheet for Paperwork \(03/2013\)](#)
- [Authorization for Health Disclosure \(03/2003\)](#)
- [Blanket Denial Request for TPL \(07/2012\)](#)

Adjustment Form

- ✓ Complete all required sections.
- ✓ Make sure the information is legible.
- ✓ Double-check that your adjustments are correct.
- ✓ Attach a copy of the remittance advice with Reason and Remark Codes.
- ✓ Do not adjust a denied claim.

Montana Health Care Programs Medicaid • Mental Health Services Plan • Healthy Montana Kids Individual Adjustment Request

Instructions:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete only the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advice and Adjustments chapter in your program manual or the *General Information for Providers* manual, or call Provider Relations at 1.800.624.3958 (Montana and out-of-state providers) or 406.442.1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name and Address Name _____ Street or P.O. Box _____ City _____ State _____ ZIP _____	3. Internal Control Number (ICN) _____
2. Member Name _____	4. NPI/API _____
	5. Member ID Number _____
	6. Date of Payment _____
	7. Amount of Payment \$ _____

B. Complete only the items which need to be corrected.

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature _____ Date _____

When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to:
Claims
P.O. Box 8000
Helena, MT 59604

Section A



Montana Health Care Programs Medicaid • Mental Health Services Plan • Healthy Montana Kids Individual Adjustment Request

Instructions:

This form is for providers to correct a claim which has been **paid** at an incorrect amount or was **paid** with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete **only** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in your program manual or the *General Information for Providers* manual, or call Provider Relations at 1.800.624.3958 (Montana and out-of-state providers) or 406.442.1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.	
1. Provider Name and Address The Clinic Name	3. Internal Control Number (ICN) 214010001200000
123 Main Street Street or P.O. Box	4. NPI/API 1234567891
Anywhere MT 59991 City State ZIP	5. Member ID Number 1133111
2. Member Name John Doe	6. Date of Payment 01/01/2013
	7. Amount of Payment \$ 558.86



Section B

B. Complete only the items which need to be corrected.			
Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	Line 3	4	2
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature John R. Smith, M.D. Date 02/02/2014

When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to:

Claims
P.O. Box 8000
Helena, MT 59604



Updated 03/2013

Remittance Advice

Must Be Attached to Request!

AS OF 08/08/2013

HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

THE CLINIC
123 MAIN STREET
ANYWHERE, MT 59999

VENDOR # 0000121754 REMIT ADVICE # 228928 EFT/CHK # DATE 08/12/2013 PAGE 2

RECIPIENT ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES	
PAID CLAIMS - MISCELLANEOUS CLAIM										
ICN 0132		06012013	06302013	30.000	T2031 UA	1878.90	1878.90			
	PATIENT NUMBER=									
		CLAIM TOTAL**				1878.90	1878.90			
PAID CLAIM TOTALS - MISCELLANEOUS CLAIM		**NUMBER OF CLAIMS-		1	1878.90	1878.90				
CLAIMS PENDING: MISCELLANEOUS CLAIM										
ICN 0132		06012013	06302013	30.000	T2031 UA	1878.90	0.00		133	
	PATIENT NUMBER=									
CLAIMS PENDING TOTALS -MISCELLANEOUS CLAIM		**NUMBER OF CLAIMS-		1	1878.90	0.00				
		TOTAL WARRANT AMOUNT					1878.90			

Reason and Remark Codes

HOpR: Standardized these codes.

See R&R EOB Crosswalk for further explanation.

*****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE *****

- B13 PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
- B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
- B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
- MA04 SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER NOT REPORTED OR WAS ILLEGIBLE.
- M57 MISSING/INCOMPLETE/INVALID PROVIDER IDENTIFIER.
- M68 MISSING/INCOMPLETE/INVALID ATTENDING OR REFERRING PHYSICIAN IDENTIFICATION.
- M77 MISSING/INCOMPLETE/INVALID PLACE OF SERVICE.
- M86 SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
- N30 PATIENT INELIGIBLE FOR THIS SERVICE.
- 125 PAYMENT ADJUSTED DUE TO A SUBMISSION/BILLING ERROR(S). ADDITIONAL INFORMATION IS SUPPLIED USING THE REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
- 133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.
- 15 PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER.
- 22 PAYMENT ADJUSTED BECAUSE THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.
- 29 THE TIME LIMIT FOR FILING HAS EXPIRED.
- 31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.



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