Montana Healthcare 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 remittance statement. Complete **only** the items in Section B that represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in 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 for information.

1. Provider Name, Address, and Telephone Number

____
Name

____
Street or P.O. Box

____
City State ZIP

____
Telephone Number

2. Member Name

____

3. Internal Control Number (ICN) ______________________________

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 completed and signed, attach a copy of the remittance advice. A copy of the corrected claim is optional. Mail to Claims, P.O. Box 8000, Helena, MT 59604, or fax to (406) 442-4402.