INSTRUCTIONS FOR COMPLETING 210 ADJUSTMENT/VOID FORM (ADULT)

1	Adj/Void	Check the appropriate box.
2-4	Patient's Last Name, First Name, MI	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
5	Medical Assistance ID Number	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.
6	Patient's Address	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
7	Date of Birth	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
8	Sex	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
9-14		Not required.
15	Patient ID/Account Number (Assigned By Dentist)	**Adjust -** Enter the information exactly as it appeared on the original invoice. **Void** – Enter the information exactly as it appeared on the original invoice.

16	Pay to Dentist or Group	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
17	Pay to Dentist or Group Provider No.	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.
18	Are X-Rays Enclosed	Not required.
19	Treatment Necessitated By	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
20	Payment Source Other Than Title XIX	**Adjust** - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. **Void** - Enter the information exactly as it appeared on the original invoice.
21		Not required.
22		Leave blank.
23	A- G	**Adjust** - Enter the information exactly as it appeared on the original invoice unless this information is being adjusted. **Void** - Enter the information exactly as it appeared on the original invoice.
24	Paid of Payable by Other Carrier	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party

		insurer. If such payment has been made, indicate the amount paid, even if zero ($0).
		Void - Enter the information exactly as it appeared on the original invoice.
25	Other Information	Leave blank.
26	Control Number	Enter the control number assigned to the claim on the Remittance Advice that reported the paid or denied claim.
27	Date of Remittance Advice	Enter the date of the Remittance Advice that paid or denied the claim.
28 & 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.
30-31		Leave these spaces blank.
32	Attending Dentist's Signature - Provider Number	All adjustment forms must be signed, and the provider number must be entered.

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Molina for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

FOR PREAUTHORIZATION MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119

FOR PAYMENT REMIT TO:
DXC Technology
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040

LOUISIANA DEPARTMENT OF HEALTH

BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
ADULT DENTAL SERVICES

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

2 PATIENT'S LAST NAME (PRINT) | 3 FIRST NAME | 4 MI | 5 MEDICAL ASSISTANCE I.D. NUMBER

6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.) | 7 DATE OF BIRTH | 8 SEX ☐ M ☐ F

9 REFERRING AGENCY NO. | 10 DATE OF REFERRAL | 11 | 12 DENTIST OR GROUP REFERRED TO: NAME / ADDRESS / TEL. NO.

13 REFERRED BY: (SIGNATURE) | 14 TELEPHONE NO. | 15 PATIENT I.D. / ACCOUNT # ASSIGNED BY DENTIST

16 PAY TO DENTIST OR GROUP
NAME
ADDRESS
CITY ST. ZIP

17 PAY TO DENTIST OR GROUP PROVIDER NO.

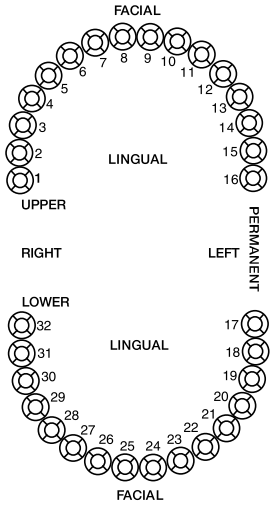
18 ARE X-RAYS ENCLOSED? ☐ YES ☐ NO
NUMBER OF X-RAYS

19 TREATMENT NECESSITATED BY:
A. EMPLOYMENT ☐ YES ☐ NO
B. ACCIDENT/INJURY ☐ YES ☐ NO

20 PAYMENT SOURCE OTHER THAN TITLE XIX
TPL CARRIER CODE:
1.
2.
3.

21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? ☐ YES ☐ NO

22



INDICATE TEETH TO BE EXTRACTED WITH A/.

INDICATE MISSING TEETH WITH AN X.

SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND TEETH TO BE CLASPED.

23 A. PROCEDURE CODE	B. DESCRIPTION OF SERVICE	C. DATE SERVICE PERFORMED MO. DAY YEAR	D. ADJUSTED FEE (FOR STATE USE ONLY)	E. USUAL AND CUSTOMARY FEE
F. ORAL CAVITY	G. TOOTH #		24 PAID OR PAYABLE BY OTHER CARRIER	$

25 (1) IS THE PATIENT EDENTULOUS?
MAXILLARY: NO ☐ YES ☐ DATE OF LAST EXTRACTIONS ___/___/___
MANDIBULAR: NO ☐ YES ☐ DATE OF LAST EXTRACTIONS ___/___/___

(2) DOES PATIENT PRESENTLY WEAR A DENTURE? DATE OF PLACEMENT.
MAXILLARY: NO ☐ YES ☐ FULL ☐ PARTIAL ☐ MO. ____ YR. ____
MANDIBULAR: NO ☐ YES ☐ FULL ☐ PARTIAL ☐ MO. ____ YR. ____

COMMENTS:

INFORMATION FROM PATIENT
(1) IN WHAT MONTH AND YEAR WAS YOUR LAST DENTURE MADE? UPPER ____ LOWER ____
(2) NAME AND ADDRESS OF DENTIST
(3) HAVE YOU EVER RECEIVED A DENTURE UNDER THE MEDICAID PROGRAM? YES ☐ NO ☐

26 CONTROL NUMBER

THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.

28 REASONS FOR ADJUSTMENT
☐ 01 THIRD PARTY LIABILITY RECOVERY
☐ 02 PROVIDER CORRECTIONS
☐ 03 FISCAL AGENT ERROR
☐ 90 STATE OFFICE USE ONLY - RECOVERY
☐ 99 OTHER - PLEASE EXPLAIN

29 REASONS FOR VOID
☐ 10 CLAIM PAID FOR WRONG RECIPIENT
☐ 11 CLAIM PAID TO WRONG PROVIDER
☐ 99 OTHER - PLEASE EXPLAIN

I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

30 REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER DATE

31 REQUEST FOR AUTHORIZATION (FOR STATE USE ONLY)
APPROVED YES ☐ NO ☐ W/EXCEPTIONS ☐

32
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER

MEDICAID PAYMENTS: I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED UNDER THE STATE'S TITLE XIX PLAN AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED FOR PROVIDING SUCH SERVICES AS THE STATE AGENCY OR ITS AUTHORIZED REPRESENTATIVE MAY REQUEST FOR FIVE YEARS FROM DATE OF SERVICE. I FURTHER AGREE TO ACCEPT, AS PAYMENT IN FULL, THE AMOUNT PAID IN ACCORDANCE WITH THE FEE STRUCTURE OF THE MEDICAID PROGRAM FOR THOSE CLAIMS SUBMITTED FOR PAYMENT UNDER THAT PROGRAM.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I CERTIFY THAT THE SERVICES LISTED ON THE REVERSE WERE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND WERE PERSONALLY RENDERED BY ME OR UNDER MY PERSONAL DIRECTION.

NOTICE: THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.