ADJUSTING/VOIDING CLAIMS

Blank adjustment/void forms can be obtained from Provider Relations at (800) 473-2783 or downloaded from www.lamedicaid.com by clicking on the Forms/Files link.

Only one claim line can be adjusted or voided on each adjustment/void form.

Only a **paid** claim can be adjusted or voided.

Electronic submitters may electronically submit adjustment/void claims.

Only the paid claim's **most recently approved** control number can be adjusted or voided. For example:

A claim is paid on the RA dated 1/03/07, ICN 760056789100.

The claim is adjusted on the RA dated 3/07/07 ICN 760056789100.

All additional adjustment or voids on this claim would need to use ICN 760056789100.

Provider numbers and recipient Medicaid ID numbers cannot be adjusted. They must be voided then resubmitted.

To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the RA. The original payment will be taken back on the same RA in the "previously paid" column.

To file a void, the provider must enter all the information from the original claim exactly as it appeared on the original claim. When the void claim is approved, it will be listed under the "void" column of the RA and a corrected claim may be submitted (if applicable).

INSTRUCTIONS FOR COMPLETING THE 213 ADJUSMENT/VOID FORM

1. **REQUIRED** ADJ/VOID—Check the appropriate block

2. **REQUIRED** Patient's Name
   a. Adjust—Print the name exactly as it appears on the original claim if not adjusting this information
   b. Void—Print the name exactly as it appears on the original claim

3. Patient's Date of Birth
   a. Adjust—Print the date exactly as it appears on the original claim if not adjusting this information
   b. Void—Print the name exactly as it appears on the original claim

4. **REQUIRED** Medicaid ID Number—Enter the 13 digit recipient ID number

5. Patient's Address and Telephone Number
   a. Adjust—Print the address exactly as it appears on the original claim
   b. Void—Print the address exactly as it appears on the original claim

6. Patient's Sex
   a. Adjust—Print this information exactly as it appears on the original claim if not adjusting this information
   b. Void—Print this information exactly as it appears on the original claim

7. Insured's Name— Leave blank

8. Patient's Relationship to Insured—Leave blank

9. Insured's Group No.—Complete if appropriate or leave blank

10. Other Health Insurance Coverage—Complete with 6-digit TPL carrier code if appropriate or leave blank

11. Was Condition Related to—Leave blank

12. Insured's Address—Leave blank

13. Date of—Leave blank

14. Date First Consulted You for This Condition—Leave blank

15. Has Patient Ever had Same or Similar Symptoms—Leave blank

16. Date Patient Able to Return to Work—Leave blank

17. Dates of Total Disability-Dates of Partial Disability—Leave blank

18. Name of Referring Physician or Other Source—Leave this space blank

18a. Referring ID Number—Enter the CommunityCARE authorization number if applicable or leave blank

19. For Services Related to Hospitalization Give Hospitalization Dates—Leave blank

20. Name and Address of Facility Where Services Rendered (if other than home or office)—Leave blank

21. Was Laboratory Work Performed Outside of Office—Leave blank

22. **REQUIRED** Diagnosis of Nature of Illness
   a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information
   b. Void—Print the information exactly as it appears on the original claim

23. Attending Number—Enter the attending number submitted on original claim, if any, or leave this space blank

24. Prior Authorization #—Enter the PA number if applicable or leave blank

25. **REQUIRED** A through F
   a. Adjust—Print the information exactly as it appears on the original claim if not adjusting the information
   b. Void—Print the information exactly as it appears on the original claim

26. **REQUIRED** Control Number—Print the correct Control Number as shown on the Remittance Advice

27. **REQUIRED** Date of Remittance Advice that Listed Claim was Paid—Enter MM DD YY from RA form

28. **REQUIRED** Reasons for Adjustment—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary

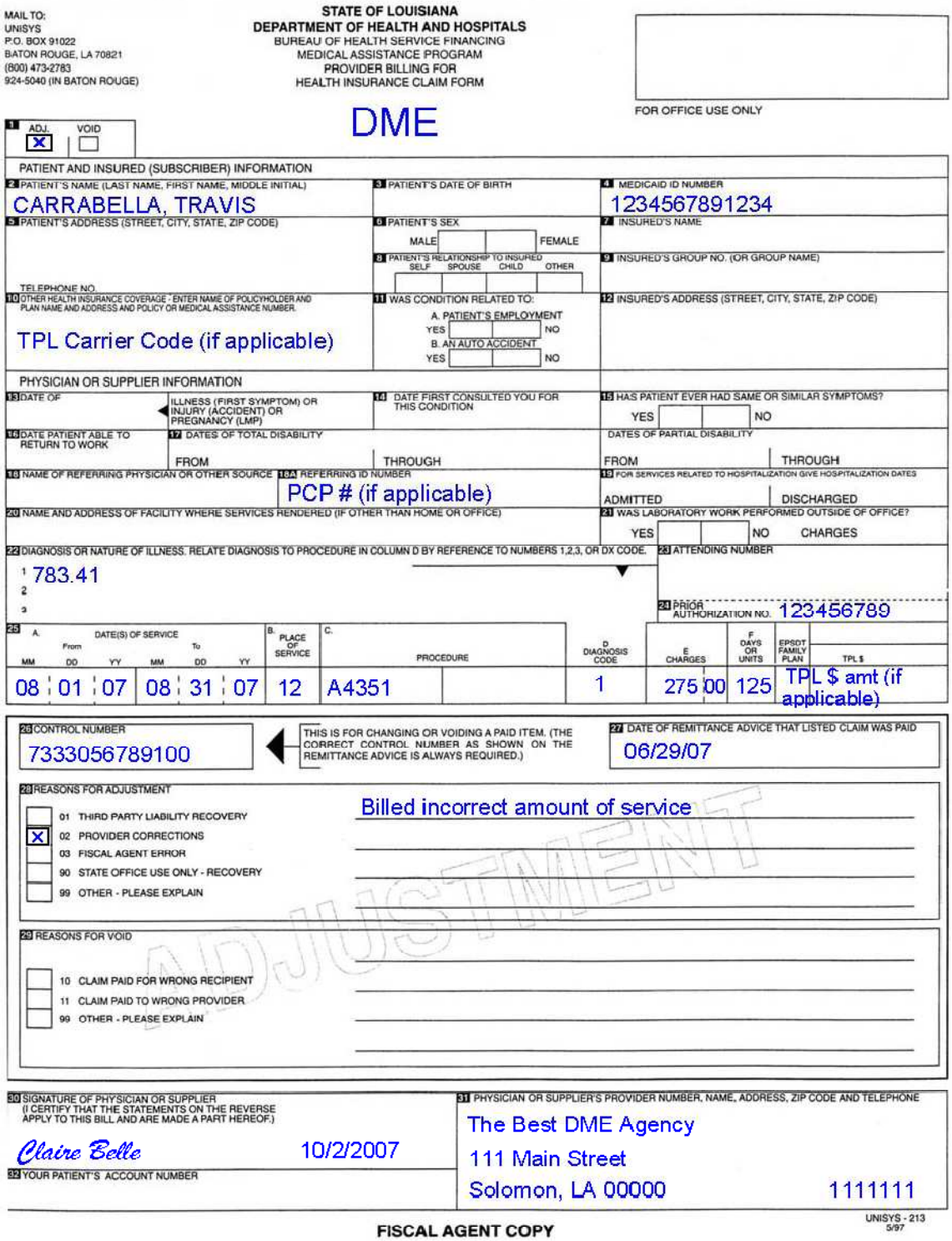
29. **REQUIRED** Reasons for Void—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary

30. **REQUIRED** Signature of Physician or Supplier—All Adjustment/Void forms must be signed

31. **REQUIRED** Physician's or Supplier's Name, Address, Zip Code and Telephone Number—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number. *The form will be returned if this information is not entered.*

32. Patient's Account Number—Enter the patient's provider-assigned account number.

REQUIRED items must be completed or the form will be returned.



MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

DME

FOR OFFICE USE ONLY

1. ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): CARRABELLA, TRAVIS
3. PATIENT'S DATE OF BIRTH:
4. MEDICAID ID NUMBER: 1234567891234
5. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6. PATIENT'S SEX: MALE [ ] FEMALE [ ]
7. INSURED'S NAME
8. PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9. INSURED'S GROUP NO. (OR GROUP NAME)
10. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
TPL Carrier Code (if applicable)
11. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. AN AUTO ACCIDENT YES [ ] NO [ ]
12. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14. DATE FIRST CONSULTED YOU FOR THIS CONDITION
15. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]
16. DATE PATIENT ABLE TO RETURN TO WORK
17. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A. REFERRING ID NUMBER: PCP # (if applicable)
19. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21. WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO [ ] CHARGES
22. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 783.41
2
3
23. ATTENDING NUMBER
24. PRIOR AUTHORIZATION NO.: 123456789

25. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
08	01	07	08	31	07	12	A4351		1	275 00	125		TPL $ amt (if applicable)

26. CONTROL NUMBER: 7333056789100
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: 06/29/07

28. REASONS FOR ADJUSTMENT
[ ] 01 THIRD PARTY LIABILITY RECOVERY
[X] 02 PROVIDER CORRECTIONS
[ ] 03 FISCAL AGENT ERROR
[ ] 90 STATE OFFICE USE ONLY - RECOVERY
[ ] 99 OTHER - PLEASE EXPLAIN
Billed incorrect amount of service

ADJUSTMENT

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

30. SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Claire Belle 10/2/2007
32. YOUR PATIENT'S ACCOUNT NUMBER

31. PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
The Best DME Agency
111 Main Street
Solomon, LA 00000 1111111

FISCAL AGENT COPY

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