Oklahoma HealthCare Authority

CMS-1500, DENTAL, CROSSOVER PART B PAID CLAIM ADJUSTMENT REQUEST

Mail completed requests to: OHCA - Adjustments, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105
Mail Refunds to: OHCA- Finance, P.O. Box 18299, Oklahoma City, OK 73154-0299

1) PROVIDER NUMBER: _____

PROVIDER NAME/ADDRESS:

PHONE NUMBER: _____

CONTACT PERSON: _____

(2) REASON FOR ADJUSTMENT: (Check appropriate Box)

- ☐ **Change TPL Amt.** (Attach all EOMB's that apply)
- ☐ **Offset or Refund of entire claim amount (check block 10)**
- ☐ **Change information as indicated in blocks 13-16**
- ☐ **Medicare Adjustment (Attach all EOMBs that apply to this adjustment)**

(3) CLAIM NUMBER (ICN)	(4)CLIENT ID NO.	(5) DATE OF SERVICE From: Thru:
(6) CLIENT NAME	(7) AMOUNT PAID	(8) REMITTANCE ADVICE DATE

(9) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST:

(10) TYPE OF ADJUSTMENT

- ☐ **Underpayment Adjustment**
- ☐ **Overpayment Adjustment (Deduct from from future payments)**
- ☐ **Refund Adjustment (Check attached)**

Check number:

(11) CLAIM TYPE

- ☐ **Dental**
- ☐ **Crossover**
- ☐ **CMS-1500**

(12) MEDICAID PROGRAM

- ☐ **Fee for Service**
- ☐ **SoonerCare**

LIST THE INFORMATION TO BE CORRECTED IN THE BLOCKS BELOW. IF NO LINE NO. IS ASSOCIATED WITH THE CORRECTION, ENTER A ZERO (0) IN THE LINE NUMBER FIELD. (i.e. TPL APPLIED WOULD ALWAYS BE LINE # 0.)

(13) LINE NO.	(14) DESCRIPTION OF INFORMATION TO BE CORRECTED	(15) CURRENT INFORMATION	(16) CORRECTED INFORMATION

17) SIGNATURE: _____ **(18) DATE:** _____

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
CMS-1500, DENTAL, CROSSOVER PART B PAID CLAIM ADJUSTMENT REQUEST INSTRUCTIONS

A completed adjustment request form is **required for each claim** you are requesting to be adjusted. In addition, a copy of the Remittance Advice and a copy of the corrected claim will also facilitate the adjustment process. If the adjustment request is for a Crossover claim attach a copy of the Medicare EOMB or if the request is for an adjustment to the TPL amount attach a copy of the insurance EOMB.

1	**PROVIDER NUMBER**	Enter your 9 digit billing provider number and 1 character service location
	PROVIDER NAME/ ADDRESS PHONE NUMBER	Enter your current billing name and address Enter phone number of contact person
	CONTACT NAME	Enter a contact name
2	**REASON FOR ADJUSTMENT**	Check the appropriate box for the reason you are requesting an adjustment
3	**CLAIM NUMBER (ICN)**	Enter the Internal Control Number of the claim you wish to adjust. This can be found onthe Remittance Advice. (Use the most current ICN for the claim to be adjusted.)
4	**CLIENT ID NO.**	Enter the recipient's 9 digit identification number
5	**DATES OF SERVICE**	Enter the From and Thru Dates of Service as billed on the claim
6	**CLIENT NAME**	Enter the First and Last Name of the Recipient
7	**AMOUNT PAID**	Enter the Paid Amount of the claim to be adjusted
8	**REMITTANCE ADVICE DATE**	Enter the date of your Remittance Advice on which the claim last paid
9	**EXPLANATION**	Give a clear explanation for the requested adjustment or refund
10	**TYPE OF ADJUSTMENT**	Check the appropriate box for the type of adjustment you are requesting: * Underpayment – An adjustment to a claim in which you are requesting additional payment, or for which you are requesting a change to the claim's data which will result in no net change in payment. * Overpayment – An adjustment to a claim for which you are requesting that an overpaid amount be deducted from your future payments. (This may be a recoupment of a portion of the claim or the entire amount of the claim.) * Refund – Same as overpayment except that you are submitting a refund check for the overpaid amount. (A refund may be applied to a portion of the claim or to the entire amount of the claim.)
11	**CLAIM TYPE**	Check the appropriate box of the claim type to be adjusted.
12	**PROGRAM**	Check the appropriate box of the program to which the claim to be adjusted is associated.
13	**LINE NO.**	Enter the number of the line that data is to be adjusted. If the adjusted data is not associated to a specific line on the claim, enter a zero (0) in this field
14	**DESCRIPTION**	Enter a brief description of the data that is to be corrected on the claim
15	**CURRENT INFO**	Enter the information as stated on the current claim that is to be adjusted
16	**CORRECTED INFO**	Enter the corrected information for the claim
17	**SIGNATURE**	Enter signature of appropriate person (physician, billing clerk, etc. – not required)
18	**DATE**	Enter the date you are submitting this request (Required)