State of Illinois
Illinois Department of Healthcare and Family Services

ADJUSTMENT (HOSPITAL)

AAH

1. DOCUMENT CONTROL NUMBER (Dept Use Only)

61

2. PROVIDER NAME, ADDRESS, CITY,STATE, ZIP

3. PAYEE NUMBER

4. PROVIDER NUMBER

5. PROVIDER NPI NUMBER

ADJUSTMENT TO

6. VOUCHER NUMBER

7. DOCUMENT CONTROL NUMBER

8. COS

9. DATE OF SERVICE

10. PROVIDER REFERENCE NUMBER

11. RECIPIENT NAME (FIRST, MI, LAST)

12. RECIPIENT NUMBER

13. DATE OF BIRTH

FOR PROVIDER USE ONLY

14. REASON ADJUSTMENT REQUESTED

Completion Mandatory, 305 ILCS 5/1-1 et seq. Failure to complete may result in the department taking unfavorable action. Form has been approved by the Forms Management Center.

This is to certify that the information above is true, accurate and complete

15. PROVIDER SIGNATURE

16. DATE

FOR ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

17. PROCESS TYPE

18. CAT SERVICE

19. CREDIT AMT

20. DEBIT AMT

21. REASON CODE

22. REASON ADJUSTMENT MADE OR DENIED

23. EMPLOYEE

24. DATE

25. AUTHORIZED HFS SIGNATURE