8.0 Adjustment/Void Request Form

The Division of Medicaid and the fiscal agent allow adjusting and voiding of claims. The following procedures allow providers to find solutions to payment difficulties. These procedures and forms are used to correct under/ over payments.

If you are paid incorrectly on the remittance advice for a Medicaid claim or have received monies from a third party payer after payment of Medicaid, you may submit an Adjustment/ Void Request Form to request an adjustment. Adjustment requests are used to change the original amount paid on a claim. The original payment can be increased or decreased. Void requests are used to refund the entire original payment on a claim.

When refunding money to Medicaid, it is not necessary to remit a refund check. If an adjustment will result in a reduction in the original Medicaid payment and no refund check is included, an adjustment will be made on the weekly remittance advice. If a refund check is included, the adjustment will be applied against the refund check. The only time the actual Medicaid check should ever be returned is in the rare event that all claims on the remittance advice were paid incorrectly and the entire amount is to be refunded.

An adjustment/void form cannot be used for denied claims. A denied claim must be resubmitted on the appropriate claim form, and the error must be corrected. The EOB message on the remittance advice will provide guidance for submitting the corrected claim.

If an adjustment appears on a remittance advice and is not correct, another adjustment request may be submitted using the transaction control number (TCN) from the debit line of the adjusted claim.

Billing Tip

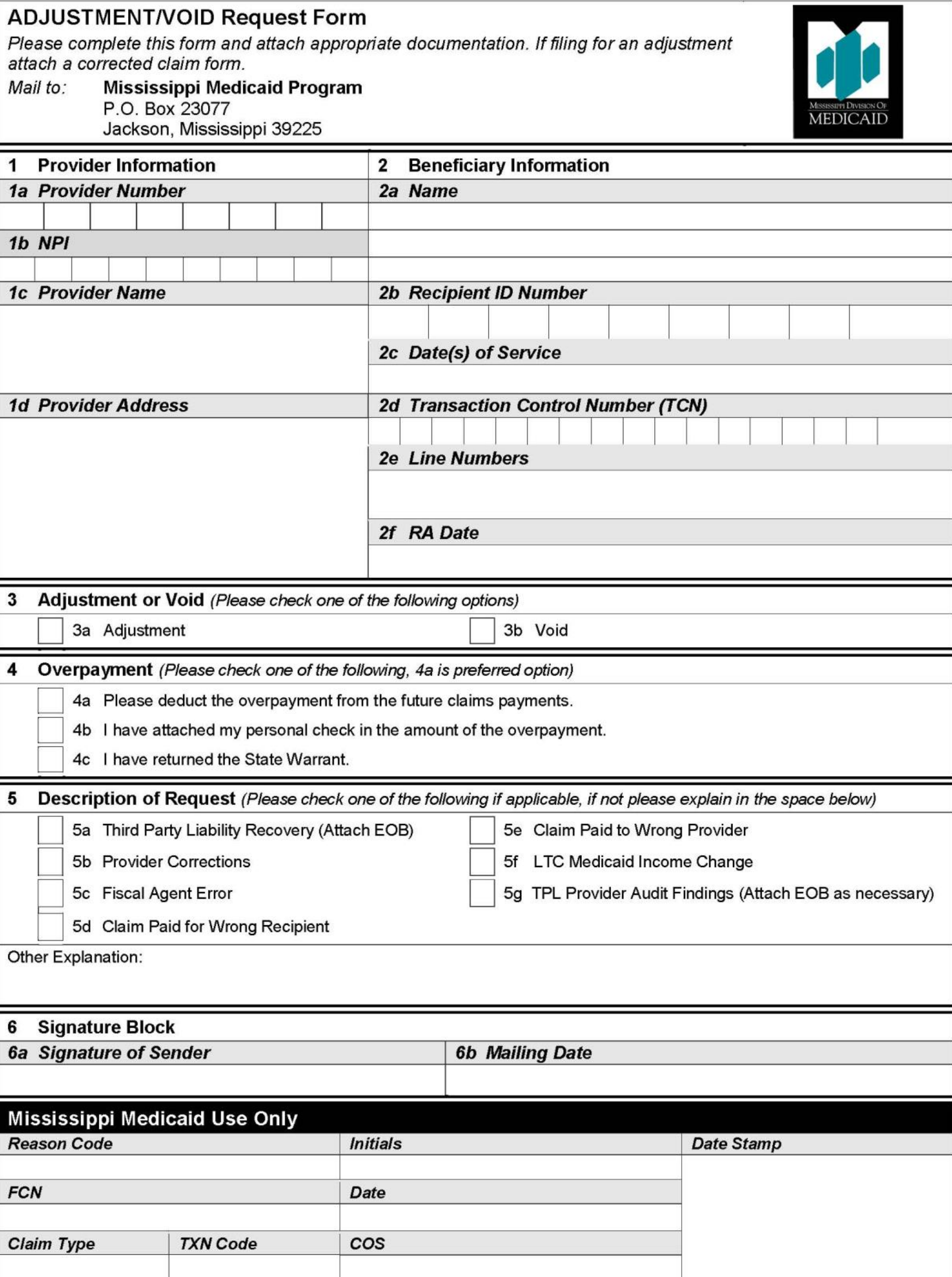
Electronically submitted claims cannot be adjusted using the adjustment/void form. Electronically submitted claims must be adjusted electronically; however, the adjustment/void form may be used to void either paper or electronically submitted claims.

Time Limit for Adjustment Requests

Positive adjustment requests must be submitted within two (2) years from the date of service as shown on the Medicaid remittance advice. When submitting adjustment requests, a copy of the original claim form and the remittance advice which reflects the payment must be attached. If money is owed to the Medicaid program (negative adjustment or voids), the 2-year filing limitation is not applicable.

Completing the Adjustment/ Void Request Form

Instructions for completing the Adjustment/ Void Request Form are on the page following the form, and correspond to the line numbers on the form. All information requested on this form is required. Submit only one request per form.



ADJUSTMENT/VOID Request Form

Please complete this form and attach appropriate documentation. If filing for an adjustment attach a corrected claim form.

Mail to: **Mississippi Medicaid Program**
P.O. Box 23077
Jackson, Mississippi 39225

MISSISSIPPI DIVISION OF MEDICAID

1 Provider Information	2 Beneficiary Information
1a Provider Number	*2a Name*
1b NPI	
1c Provider Name	*2b Recipient ID Number*
	2c Date(s) of Service
1d Provider Address	*2d Transaction Control Number (TCN)*
	2e Line Numbers
	2f RA Date

3 Adjustment or Void *(Please check one of the following options)*

- ☐ 3a Adjustment
- ☐ 3b Void

4 Overpayment *(Please check one of the following, 4a is preferred option)*

- ☐ 4a Please deduct the overpayment from the future claims payments.
- ☐ 4b I have attached my personal check in the amount of the overpayment.
- ☐ 4c I have returned the State Warrant.

5 Description of Request *(Please check one of the following if applicable, if not please explain in the space below)*

- ☐ 5a Third Party Liability Recovery (Attach EOB)
- ☐ 5b Provider Corrections
- ☐ 5c Fiscal Agent Error
- ☐ 5d Claim Paid for Wrong Recipient
- ☐ 5e Claim Paid to Wrong Provider
- ☐ 5f LTC Medicaid Income Change
- ☐ 5g TPL Provider Audit Findings (Attach EOB as necessary)

Other Explanation:

6 Signature Block

6a Signature of Sender	*6b Mailing Date*

Mississippi Medicaid Use Only

Reason Code		*Initials*	*Date Stamp*
FCN		*Date*	
Claim Type	*TXN Code*	*COS*	

All of the fields below are required. Complete the Adjustment/Void Request Form as described below:

Field	Adjustment/Void Form Instructions
1a	**Provider Number*:*** Enter 8-digit Mississippi Medicaid provider number.
1b	**NPI Number:** Enter the 10-digit National Provider Identifier of the billing provider.
1c	**Provider Name:** Enter the physician's name or name of healthcare entity.
1d	**Provider Address:** Enter the address of healthcare entity.
2a	**Name:** Enter the beneficiary's name.
2b	**Recipient ID Number:** Enter the first 9-digits of the beneficiary's Mississippi Medicaid number as it appears on the ID card omitting the last three digits found after the ID number.
2c	**Date(s) of Service:** Enter the date that the service was performed.
2d	**TCN**—Enter the transaction control number from the remittance advice. (Only enter 1 ***TCN*** per request.)
2e	**Line Numbers**—Enter the number of each line to be adjusted.
2f	**RA Date**—Enter the date of the remittance advice in which the claim originally paid.
3	**Adjustment or Void**—Check the appropriate option.
4	**Overpayment**—Check the appropriate refund option. In most cases option 4a is preferred.
4a	**Deduct Overpayment from Future Claims Payments**—Use this option in most cases.
4b	**Personal Check**—Check this option if a personal check is enclosed.
4c	**Return of State Warrant**—Check this option if the State Warrant is enclosed.
5	**Description of Request**—Check the option which best describes the reason for the request.
6a	**Signature Of Sender**—Sign the form, as it cannot be processed without a signature.
6b	**Mailing Date**—Enter the Adjustment/Void Request Form mailing date.

If the claim is being voided, no documentation for this request is required. If the claim is being adjusted, a copy of the corrected claim must be attached. A copy of the remittance advice may also be supplied. If proper documentation is not provided, the forms will be returned.

Mail the completed form to:

Mississippi Medicaid Program
P.O. Box 23077
Jackson, Mississippi 39225