Click in area to type. Click Reset button to clear form of all information, except provider number, provider name, and provider address.

Reset

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

1 Provider Information

1a Provider Number

1b Provider Name

1c Provider Address

2 Beneficiary Information

2a Name

2b Recipient ID Number

2c Date(s) of Service

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