MEDICAID CLAIM ADJUSTMENT REQUEST

(This form is not to be used for claim inquiries or time limit overrides.)
PLEASE COMPLETE THIS FORM IN BLUE OR BLACK INK ONLY

MAIL TO:
CSRA
ADJUSTMENT UNIT
PO BOX 300009
RALEIGH, NC 27622

A CORRECTED CLAIM

AND THE APPROPRIATE RA MUST BE ATTACHED

CSRA USE ONLY

Edit Override Number: _____

Provider NPI #: _____ Provider Name: _____

Recipient Name: _____ Recipient ID#: _____

SUBMIT A COPY OF THE RA WITH REQUEST

Claim #: | | | | | | | | | | | | | | | | | | | | |

Date Of Service: From: _____/_____/_____ To: _____/_____/_____

Billed Amount: $_____

Paid Amount: $_____

RA Date: _____/_____/_____

Please check (\) reason for submitting the adjustment request:

- ☐ Over Payment
- ☐ Under Payment
- ☐ Full Recoupment
- ☐ Other

Please check (\) changes or corrections to be made:

- ☐ Units
- ☐ Procedure/Diagnosis Code
- ☐ Billed Amount
- ☐ Dates of Service
- ☐ Patient Liability
- ☐ Further Medical Review
- ☐ Third Party Liability
- ☐ Medicare Adjustments (Attach all related Medicare Vouchers)
- ☐ Other

Please Specify Reason for Adjustment Request:

Signature Of Sender:

Date: / /

Phone #: ( ) -

CSRA INTERNAL USE ONLY

Clerk ID#: _____ Sent to: _____ Date sent: _____/_____/_____

Reason for review: _____

Reviewed by: _____ Date reviewed: _____/_____/_____

Outcome of review: _____

Date received back in the Adjustment Department: _____/_____/_____

Revised 12/18/13 upd