Payment Adjustment Process

A new electronic Payment Adjustment Request form for fee-for-service Medicaid claims is now available for issues regarding overpayments and credit balance. The form must accompany a payment in order to allow proper allocation of funds. To view the form, go to https://medicaid.utah.gov/utah-medicaid-forms. From the list choose the form named: Payment Adjustment Form.

This form may be filled out on the computer before printing. One form is required per claim. The form must have all required fields appropriately filled out or it will be returned to the provider for corrections

Do not use this form for changes to a claim that is less than three years old. If a payment adjustment is required on a claim that is **less than three years old, a replacement claim must be submitted**. Refer to your internal practice management policies on the procedure to submit a replacement claim. Additional information regarding how to submit a replacement claim can be found at the end of this article.

Make all checks payable to: Bureau of Medicaid Operations

Mail checks for Credit Balance, Third Party Liability for Crossover Claim Payments, and Overpayments older than three years to:

Bureau of Medicaid Operations: Payment Adjustments
P.O. Box 143106
Salt Lake City, UT 84114-3106

Payment Adjustments refer to Credit Balance payments, Third Party Liability for Crossover Claim Payments, and Overpayments due to coding adjustments **older than three years.**

Information regarding the Credit Balance is found on the letter sent to the provider, or you may call (801) 538-6513 for additional help.

Make all checks payable to: Bureau of Medicaid Operations

Mail checks for Third Party Liability payments (TPL) excluding Crossover Claim (TPL) adjustments to:

Office of Recovery Services,
Medicaid Section, Team 85
P. O. Box 45025
Salt Lake City, UT
84145-0005

For questions regarding payments sent to ORS, call (801) 741-7437

A **replacement claim** will correct units, charges including Third Party Liability (TPL) and client information. Check the **5010 Companion guide** for electronic claims submission requirements: http://health.utah.gov/hipaa/guides.htm. If you have additional questions how to submit a replacement claim, refer to your internal practice management procedure or your clearinghouse support services.

If using paper, the explanation for the CMS-1500 Claim Form is available from the insurance commissioner through the Utah Health Information Network (UHIN) website: http://uhin.org. Therefore, Utah Medicaid no longer provides an explanation for the CMS-1500 Claim Form. Providers who use the paper claim form should access the UHIN web site: http://uhin.org for CMS 1500 Paper Claim Form Standard Version 3.3. For help with either the UHINt tool or paper submission questions please contact UHIN for assistance at (801) 716-5901.

Please do not sent checks intended for a Medicaid ACO (Health Choice Utah, Healthy U, Molina Healthcare of Utah, SelectHealth Community Care, DentaQuest, or Premier Dental) to Utah Medicaid. To ensure proper reimbursement follow each ACO's guideline for returning Payment Adjustments.

PAYMENT ADJUSTMENT REQUEST

Check all that Apply:

☐ Additional information is attached.

For CLAIMS less than three years old that require a Payment Adjustment, submit a replacement claim.

Payment Adjustment type:

Make all Checks Payable to: Bureau of Medicaid Operations

☐ Credit Balance:
Fill out: Boxes 1-9 and 30 & 31.

Attach a copy of the Credit Balance letter if available.
Credit Balance refers to debt where Medicaid has sent a letter requesting money be returned.

☐ All other Payment Adjustments:
Fill out: Boxes **2-31**

If for **a** Third Party Liability adjustment an Explanation of Benefit (EOB) must be included.

1. Credit Balance:	2. Date: MM/DD/YY
3. Provider Name:	
4. Provider Address:	5. Provider City:
6. Provider State:	7. Provider Zipcode:
8. Provider Number (NPI/12 digit Provider ID):	9. Provider Tax ID:

10. Payment Adjustment:	11. Warrant Date:	12. Warrant Number:	13. Member ID Number:
14. Claim Number (TCN 17 digits):	15. Member First Name:	16. Member Last Name:	
Boxes 17-19 apply to TPL claims only	17. Third Party Liability Name:	18. Policy Holder Full Name:	19. Policy Number:
20. Explain Reason for Adjustment:			

	21. Dates of Service: MM/DD/YY		22. Days or Units	23. Procedure or Revenue			24. Explanation of Change:	25. New Charges/ Line Level TPL	26. Original Charges:
	FROM	TO		CODE	MOD	MOD			
A									
B									
C									
D									
E									
F									
G									

Contact Information

30. Provider/Provider Representative:
31. Telephone Number:

27. Total Amount:		
28. TPL (Claim Level):		
29. Net Adjustment:		

FOR STATE USE ONLY:

Explanation of denial:		
Denial Reason:	Clerk I.D.:	Date: MM/DD/YY