Payment Adjustment Process

A new electronic Payment Adjustment Request form for fee-for-service Medicaid claims is now available for issues regarding overpayment 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: **PaymentAdjustment.pdf**.

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 paid claim that is less than three years old, providers should submit a replacement claim through their practice management system or submit a claim adjustment in PRISM. Refer to your internal practice management policies on the procedure to submit a replacement claim. Additional information and training can be found here: https://medicaid.utah.gov/provider-training-0/.

Send checks for adjustments older than 3 years to:

Utah Office of Inspector General
PO BOX 143103
Salt Lake City, UT 84114-3103

Credit balances resulting from adjusting claims less than 3 years old will generally be satisfied by offsetting future claims until the credit balance reaches $0. If a provider elects to send in payment instead of allowing a credit balance to be offset completely by future claims, please include the Notice of Recovery letter that will be sent to you at the end of the week the claims are adjusted if there is still an outstanding balance. If the credit balance has already been reduced when the payment is received by Medicaid, the payment will be applied against the remaining credit balance. The remainder of the funds from that payment will be refunded to the provider.

Send checks for credit balances listed on the Notice of Recovery to:

Utah Department of Health and Human Services
Office of Financial Services
P. O. Box 143104
Salt Lake City, UT 84114-3104

Mail checks for Third Party Liability payments (excluding Medicare Crossover claim adjustments) to:

Office of Recovery Services Medicaid Section, Team 85
P. O. Box 45025
Salt Lake City, UT 84145-0025

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 here: https://medicaid.utah.gov/hipaa/providers/#companion-guides.

Please do not send checks intended for a Medicaid Managed Care Entity (MCE) to the above listed addresses. To ensure proper reimbursement follow each MCE's guideline for returning Payment Adjustments.

PAYMENT ADJUSTMENT REQUEST

Check all that apply:

☐ Additional information is attached

Make all Checks Payable to: Utah Office of Inspector General

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

Payment Adjustment type:

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

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

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):	9. PRISM ID:

10. Payment Adjustment:	11. Warrant Date:	12. Warrant Number:	13. Member ID Number:

14. Claim Number (TCN):	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	27. Total Amount:		
30. Provider/Provider Representative:	28. TPL (Claim Level):		
31. Telephone Number:	29. Net Adjustment:		

FOR STATE USE ONLY:

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