Oklahoma HealthCare Authority

UB92 AND INPATIENT/OUTPATIENT CROSSOVER ADJUSTMENT REQUEST

Mail completed requests to: OHCA - Adjustments, 4345 N. Lincoln, Oklahoma City, OK 73105

(1) PROVIDER NUMBER:

PROVIDER NAME/ADDRESS:

PHONE NUMBER:

CONTACT

PERSON:

(2) REASON FOR ADJUSTMENT:
(Check appropriate Box)

- ☐ **Change TPL Amt.** ☐ **Change Patient LIABILITY (Attach all EOMB's that apply)**
- ☐ **Offset or Refund of entire claim amount (check block 10)**
- ☐ **Change information as indicated in blocks 13-16**
- ☐ **Medicare Adjustment (Attach all EOMB's that apply to this adjustment)**

(3) CLAIM NUMBER (ICN):	**(4) Client ID NO.:**	**(5) DATE OF SERVICE:** From: Thru:
(6) Client NAME:	**(7) AMOUNT PAID:**	**(8) REMITTANCE ADVICE DATE:**

(9) TYPE OF ADJUSTMENT

- ☐ **Underpayment Adjustment**
- ☐ **Overpayment Adjustment (Deduct from future payments)**
- ☐ **Refund Adjustment (Check attached)**

Check number:

(10) CLAIM TYPE

- ☐ **Inpatient**
- ☐ **Outpatient**
- ☐ **Long Term Care**
- ☐ **Home Health**
- ☐ **Crossover**

(11) MEDICAID PROGRAM

- ☐ **Fee for Service**
- ☐ **SoonerCare Choice**
- ☐ **SoonerCare Plus**

(12) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST:

LIST THE INFORMATION TO BE CORRECTED IN THE BLOCKS BELOW. IF NO LINE NO. IS ASSOCIATED WITH THE CORRECTION, ENTER A ZERO (0) IN THE LINE NUMBER FIELD. (i.e. TPL APPLIED WOULD ALWAYS BE LINE # 0.)

(13) REV/PROC CODE.	(14) DESCRIPTION OF INFORMATION TO BE CORRECTED	(15) CURRENT INFORMATION	(16) CORRECTED INFORMATION

17) SIGNATURE: _____ **(18) DATE:** _____

Mail Refunds to: OHCA - Finance, P.O. Box 18299, Oklahoma City, OK 73154-0299

A completed adjustment request form is **required for each claim** you are requesting to be adjusted. In addition, a copy of the Remittance Advice and a copy of the corrected claim will also facilitate the adjustment process. If the adjustment request is for a Crossover claim attach a copy of the Medicare EOMB or if the request is for an adjustment to the TPL amount attach a copy of the insurance EOMB.

1	**PROVIDER NUMBER:**	Enter your 9 digit billing provider number and 1 character service location
	PROVIDER NAME/ADDRESS	Enter your current billing name and address
	PHONE NUMBER:	Enter phone number of the contact person
	CONTACT NAME:	Enter a contact name
2	**REASON FOR ADJUSTMENT:**	Check the appropriate box for the reason you are requesting an adjustment
3	**CLAIM NUMBER (ICN):**	Enter the Internal Control Number of the claim you wish to adjust. This can be found on the Remittance Advice. (Use the most current ICN for the claim to be adjusted.)
4	**CLIENT ID NO.:**	Enter the recipient's 9 digit identification number
5	**DATES OF SERVICE:**	Enter the From and Thru Dates of Service as billed on the claim
6	**CLIENT NAME:**	Enter the First and Last Name of the Recipient
7	**AMOUNT PAID:**	Enter the Paid Amount of the claim to be adjusted
8	**REMITTANCE ADVICE DATE:**	Enter the date of your Remittance Advice on which the claim last paid
9	**TYPE OF ADJUSTMENT:**	Check the appropriate box for the type of adjustment you are requesting: * Underpayment – An adjustment to a claim in which you are requesting additional payment, or for which you are requesting a change to the claim's data which will result in no net change in payment. * Overpayment – An adjustment to a claim for which you are requesting that an overpaid amount be deducted from your future payments. (This may be a recoupment of a portion of the claim or the entire amount of the claim.) * Refund – Same as overpayment except that you are submitting a refund check for the overpaid amount. (A refund may be applied to a portion of the claim or to the entire amount of the claim.)
10	**CLAIM TYPE**	Check the appropriate box of the claim type to be adjusted.
11	**PROGRAM**	Check the appropriate box of the program to which the claim to be adjusted is associated.
12	**EXPLANATION**	Give a clear explanation for the requested adjustment or refund
13	**REV/PROC CODE**	Enter the number of the line that data is to be adjusted. If the adjusted data is not associated to a specific line on the claim, enter a zero (0) in this field
14	**DESCRIPTION**	Enter a brief description of the data that is to be corrected on the claim
15	**CURRENT INFO**	Enter the information as stated on the current claim that is to be adjusted
16	**CORRECTED INFO**	Enter the corrected information for the claim
17	**SIGNATURE**	Enter signature of appropriate person (physician, billing clerk, etc. – not required) Enter
18	**DATE**	the date you are submitting this request (Required)