***Dates of service with FROM dates on or after 1/1/2024 must be sent to the member assigned MCO**

ADJUSTMENT/VOID REQUEST COMPLETION INSTRUCTIONS FOR DATES OF SERVICE WITH FROM DATES ON OR BEFORE 12/31/2023

In accordance with TennCare Policy No PL 08-001 (Rev.3), The Tennessee Medicaid False Claims Act (TMFCA) applies solely to false claims submitted to the Medicaid Program. The TMFCA requires that civil and/or administrative actions be brought against any person who:

- Presents or causes to be presented, to the State of Tennessee a claim for payment under the Medicaid program knowing such claim is false or fraudulent;
- Makes, uses, or causes to be made or used, a record or statement to get a false or fraudulent claim under the Medicaid program paid for or approved by the State knowing such record or statement is false;
- Conspires to defraud the State by getting a claim allowed or paid under the Medicaid program knowing such claim is false or fraudulent; or
- Makes, uses, or causes to be made or used, a record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State, relative to the Medicaid program, knowing such record or statement is false.

The TMFCA imposes a civil penalty plus three times the amount of damages to the State because of the violations.

The Adjustment/Void Request form is used by TennCare to adjust or void an allowed claim (a paid or partially paid claim) for dates of service with FROM dates on or before 12/31/2023. Providers may request an adjustment when claim data needs to be changed or corrected. TennCare requires certain information to enable the program to adjust or void paid services for eligible recipients.

The Adjustment\Void Request form is reviewed by TennCare based on the information provided. Therefore, providers are required to give full, correct, and truthful information for the submission of correct and complete adjudication. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and/or recipient ID.

Send Adjustment/Void Request Forms submitted with a **REFUND CHECK** to:

State of Tennessee
Division of TennCare
Attention: Fiscal Budget,
4E 310 Great Circle Road
Nashville, TN 37243-1700

Send **ALL OTHER** completed Adjustment/Void Request Forms to:

State of Tennessee
Division of TennCare
P.O. Box 1700
Nashville, TN 37202-1700

INSTRUCTIONS

SECTION I – BILLING PROVIDER INFORMATION

1. Name – Billing Provider

Enter the Billing provider's name.

2. Billing Provider's NPI or Medicaid Number for Atypical Providers Only

Enter the Billing Provider's 10-digit National Provider Identifier (NPI) or 7-digit Medicaid Number for Atypical Providers Only. An Atypical provider is defined by CMS as a non-healthcare provider (e.g., taxi services and home delivered meals).

3. Billing Provider's Phone Number

Enter the Billing Provider's phone number.

4. Contact Name

Enter the name of the authorized representative.

5. Billing Provider's Address

Enter the Billing Provider's address.

SECTION II – CLAIM INFORMATION

6. Claim Number

Enter the 13-digit claim number from the TennCare Remittance Advice (RA).

7. Remittance Advice Date

Enter the date of the RA (found at the top right corner of the RA).

8. Billed Amount

Enter the total billed amount of the claim that was submitted to TennCare.

9. Paid Amount

Enter the total paid amount.

10. Recipient ID#

Enter either the 11-digit Recipient ID (RID) or the Social Security Number (SSN) of the recipient.

11. Recipient – Name

Enter the complete name of the member for whom payment was received, as it appears on the TennCare RA.

12. From Date of Service

Enter the "From" date of service in MM/DD/CCYY format.

13. To Date of Service

Enter the "To" date of service in MM/DD/CCYY format.

SECTION III – THIRD PARTY LIABILITY Information

14. Other Insurance EOB is required.

If a recipient has other insurance, complete the Third Party Liability Update Request Form
TPL Form: https://www.tn.gov/content/dam/tn/tenncare/documents/TPLFORM.pdf

a. Insurance Company - Name of the third party company
b. Policy # - Policy number of the third party company
c. Name of Insured - Name of the member that holds the third part company policy
d. Claim # - Claim number that the third party paid under
e. Amount Paid by Third Party - Total amount paid on claim by third party

SECTION IV – TYPE OF REQUEST

Select the the appropriate button for Adjustment or Void

15. If adjustment, select one of the reasons for the request:

a. Underpayment.
b. Overpayment – Refund check attached.
c. Overpayment – Deduct from future payment.
d. TPL Payment – Other insurance EOB required.

16. Give specific reason for the adjustment or void.

SECTION V – LIABILITY AMOUNT (For Nursing Facility Providers only)

Include a copy of the 2362 form when submitting an Adjustment/Void Request form as a result of a change in the liability amount.

17. Monthly Liability Amount

Enter the recipient's monthly liability amount as shown on the 2362 form.

18. Effective Date

Enter the effective date of the liability.

SECTION VI – SIGNATURE

19. Signature

Signature of the Authorized Representative.

20. Date

Enter the date form was signed.

NOTE:

When requesting an **ADJUSTMENT** to a previously paid claim, you will need to submit:

- a new claim (official red and white)
- the Medicare EOMB
- the TPL EOB (if applicable)
- If the required documents are not attached to the AV form, the AV form will be rejected and returned to the provider requesting the required information.

When requesting a **VOID** to a previously paid claim, no documentation is needed with the AV form; however, you must be very specific in your description as to "why" the void is being requested by your facility.

- If there is not a detailed explanation for the request in the description, the AV form will be rejected and returned to the provider requesting the required information.

If you select Overpayment as the Adjustment Reason, send this completed form with the REFUND CHECK to:
State of Tennessee
Division of TennCare
Attention: Fiscal Budget, 4E
310 Great Circle Road
Nashville TN, 37243-1700

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION

DIVISION OF TENNCARE
P.O. BOX 1700
NASHVILLE, TN 37202-1700

Send ALL OTHER completed Adjustment/Void Forms to:
State of Tennessee
Division of TennCare
P.O. Box 1700
Nashville, TN 37202-1700

Medicaid-Title XIX Adjustment/Void Request Form

By completing this form, the provider certifies that all the information is true and correct. For questions, providers may call 1-800-852-2683. **Before completing, please read the Adjustment/Void Request Completion Instructions**.

Type or Print clearly.

SECTION I – Billing Provider

1. Name – Billing Provider	2. Billing Provider's NPI or Medicaid ID (Atypical Providers Only)
3. Billing Provider's Phone Number	4. Contact Name (Authorized Representative)
5. Billing Provider's Address	

SECTION II – Claim Information – Use Information from Remittance Advice

6. Claim Number (13-digits)	7. RA Date	8. Billed Amount	9. Paid Amount

10. Recipient ID#	11. Recipient – Name (Last, First, MI)	12. From Date of Service	13. To Date of Service

SECTION III – Third Party Liability Information (Other Insurance EOB Required)

14. If Adjustment or Void is due to third party payment, complete the information below. For TPL updates, compete the TPL Update Request form. TPL Form: https://www.tn.gov/content/dam/tn/tenncare/documents/TPLFORM.pdf

a. Insurance Company	b. Policy #

c. Name of Insured	d. Claim #	e. Amount Paid by Third Party

SECTION IV – Type of Request: ☐ ADJUSTMENT ☐ VOID

15. Reason for Adjustment:

a. ☐ Underpayment
b. ☐ Overpayment – Refund check attached
c. ☐ Overpayment – Deduct from future payment
d. ☐ TPL Payment – Other insurance EOB required

16. Give Description of Request:

Section V – Patient Liability Amount (For Nursing Facility Providers Only) A copy of the 2362 form is required

17. Monthly Patient Liability Amount	18. Effective Date

Section VI - Signature

I request that reprocessing of the claim be made with the information given above. I hereby certify that the above claim for services is true and correct. I further understand and agree that the conditions on the reverse side of the claim form and the conditions in the appropriate Provider Manual apply to this claim.

19. Signature	20. Date

Reset Form