AV	MEDICAID-TITLE XIX ADJUSTMENT/ VOID REQUEST

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

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

I. Provider Information

a) ______________________________
Name

b) ______________________________
Street Address

c) ____________________ TN ________
City State Zip

d) Provider No. ____________________

IF YOU CHECK THIS BOX (b) PLEASE SEND THE REFUND CHECK AND THIS COMPLETED FORM TO:
State of Tennessee
Bureau of TennCare, Floor 4 East
Attention: Fiscal Budget
310 Great Circle Road
Nashville, TN 37243-1700

ALL OTHER COMPLETED ADJUSTMENT/VOID REQUESTS SHOULD BE SENT TO:
State of Tennessee
Bureau of TennCare
P.O.Box 1700
Nashville, TN 37202-1700

II. a) Underpayment ☐ b. Overpayment – refund check ☐ c. Overpayment – Please deduct from future claims payment ☐

III. Give Reason for Request:

IV. TPL information – If AV request is due to third party payment, complete the following, or attach a copy of check received:

a) Insurance Co. ____________________ b) Policy # ____________________

c) Name of Insured ____________________ d) Claim # ____________________

e) Amount Paid by Third Party ____________________ f) SSN # ____________________

g) DOB____________________ h) Policy Termination Date____________________

i) Policy Effective Date____________________

V. PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

a) Claim # ____________________ b) Recipient ID#____________________

c) Patient Name ____
Last First MI

d) Remittance Advice Date ____________________ e) Date of Service ____________________

f) Billed Amount ____________________ g) Paid Amount ____________________

FOR LTSS PROVIDER USE ONLY	Monthly Patient Liability Amount____________________ Effective Date____________________

VI. 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 this claim and conditions in the appropriate Provider Manual apply to this claim.

Signature ____ Date ____________________

Note: Please attach a corrected claim copy.

INSTRUCTIONS FOR COMPLETING FORM

<u>PLEASE NOTE</u>: ***A SEPARATE ADJUSTMENT/VOID REQUEST FORM MUST BE COMPLETED AND SUBMITTED FOR EACH CLAIM LINE YOU WOULD LIKE TO ADJUST OR VOID.***

1. **Provider Information**
   a) **Provider name: Enter name of provider.**
   b) **Street Address: Enter the street address of the facility.**
   c) **City, State, Zip: Enter the City and Zip Code of the facility.**
   d) **Provider Number: Enter your 7-digit provider number.**
2. **Check the 'Refund Due' box.**
3. **Give the reason for the Refund Request: Give the specific reason for your request for a refund.**
4. **TPL Information: If Refund Request is due to third party payment, complete items (a) through (i) or attach a copy of the check received from the insurance company.**
5. **Refer to your Remittance Advice for the following data. Enter all data requested.**
   a) **Claim Number: Enter the 13-digit claim number found on the R/A.**
   b) **Patient Name: Enter the patient's last name, first name, and middle initial.**
   c) **Recipient ID Number: Enter the 11-digit recipient identification number exactly as it is found on the R/A.**
   d) **Remittance Advice Date: Enter the date of the Remittance Advice found at the top right corner of the R/A.**
   e) **Date of Service: Enter the Date of Service.**
   f) **Billed Amount: Enter the amount actually billed.**
   g) **Monthly Patient Liability: Enter the complete liability shown on the 2362 and the effective date (ICF/SNF use only).**
6. **Signature: Signature of the requestor and the date the request was prepared.**

I hereby certify that the claim for services listed on the reverse of this form is true and correct; that the amount is due; that the amount received (as determined by the Single State Agency within limits defined by State and Federal laws) will be accepted as full payment for all services rendered the patient as set forth heron; that no unlisted payment is due or has been received; and that no third party payments will be accepted in excess of the determined usual and customary charges for services rendered or directed by the physician/practitioner; that the physician/practitioner is licensed to practice under the laws of the State of Tennessee or other state in which services were rendered; that pertinent medical information will be made available to authorized representatives of the State Agency subject to appropriate legal, ethical and professional limitations; and that this claim for payment under Medicaid-Title XIX Program is for services rendered to a properly identified eligible recipient. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the States Title XIX plan and to furnish information regarding any payments claimed for providing as the State Agency may request for three years from date of service. The State Agency operates under the provisions of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Under the provisions of these Acts any provider of services receiving Federal funds must comply with the intent of these Acts, and this means there shall be no discrimination because of race, color, national origin or handicap. These Acts also provide for strict compliance and complaint procedures. I understand that payment and satisfaction of this claim will be Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable Federal and State laws.