Section	Field #	Field Name	Action
A	1a	Claim Adjustment	Mark this box if any adjustments need to be made to a claim. Attach a copy of the claim with corrections made in red ink. Sections B and C must be completed.
	1b	Void Claim	Mark this box if an entire claim needs to be voided. Attach a copy of the claim or the Remittance Advice.
	2	Cancellation of the Entire Remittance Advice	Mark this box if an error or change would result in a **complete** refund of the EqualityCare payment. Attach a copy of the Remittance Advice and the EqualityCare check. Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances. (Skip to Section C)
B	1	17-digit TCN	Enter the 17-digit transaction control number assigned to each claim from the Remittance Advice.
	2	Date of Service	Enter the Date of Service
	3	9-digit Provider or 10-digit NPI Number	Enter your 9-digit EqualityCare provider number or 10-digit NPI number, if applicable.
	4	Provider Name	Enter your provider name.
	5	10-digit Client Number	Enter the client's 10-digit EqualityCare ID number.
	6	10-digit PA Number	Enter the 10-digit EqualityCare Prior Authorization number, if applicable.
	7	Reason for Adjustment or Void	Indicate if this is an adjustment or void. Enter the specific reason and any pertinent information that may assist ACS.
C		Provider Signature and Date	Signature of the provider or the provider's authorized representative and the date.