

Adjustment/void Request Form

EXHIBIT 6.9

ADJUSTMENT/VOID REQUEST FORM

SECTION A: CHECK BOX 1a), 1b) OR 2)

1a) CLAIM ADJUSTMENT: Attach a copy of the claim with corrections made in **red ink**.
DO NOT USE HIGHLIGHTER

1b) VOID CLAIM: Attach a copy of the claim or Remittance Advice.

Complete Sections B and C.
If attaching a check, the check should be payable to **Office of Healthcare Financing.**

2) CANCELLATION OF THE ENTIRE REMITTANCE ADVICE. Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances.

Complete Section C only.
Attach RA and EqualityCare check

SECTION B

TO FACILITATE CLAIM ADJUSTMENT PROCESSING, PLEASE COMPLETE THE FOLLOWING:

1. 17-DIGIT TCN:

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2. PAYMENT DATE:

3. 9-DIGIT PROVIDER OR 10-DIGIT NPI NUMBER:

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4. PROVIDER NAME:

5. 10-DIGIT CLIENT NUMBER:

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6. 10-DIGIT PA NUMBER:

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7. REASON FOR ADJUSTMENT OR VOID:

SECTION C: SIGNATURE AND DATE REQUIRED

PROVIDER SIGNATURE: _____ DATE: _____

RETURN ALL REQUESTS TO:
ACS
P.O. BOX 547
CHEYENNE, WY 82003-0547

REMARKS/STATUS:

(FOR ACS USE ONLY)

CASH CONTROL NUMBER: _____

ADJUSTED BY: _____ DATE: _____