

**ADJUSTMENT REQUEST FORM - MEDICAID XIX**

MAIL TO: EDS Corporation; Adjustments; P.O. Box 8036; Little Rock, Arkansas 72203  
IMPORTANT: If all required information is not complete, the form will be returned to provider.

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Provider Number: \_\_\_\_\_  Overpayment: Please process to correct the overpayment.  
Provider Name: \_\_\_\_\_  Underpayment: Please process to correct the underpayment.  
Address: \_\_\_\_\_  Informational Corrections: Please process to reflect the correct information.  
\_\_\_\_\_

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*PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:*

Claim Number: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Recipient I.D. Number: \_\_\_\_\_ Remittance Advice Date: \_\_\_\_\_  
Date(s) of Service: \_\_\_\_\_  
Billed Amount: \_\_\_\_\_ Paid Amount: \_\_\_\_\_

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Description of the Problem:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**EDS USE ONLY**

\_\_\_\_\_ Date of Adjustment Reviewer: \_\_\_\_\_

Adjustment Action:

\_\_\_\_\_ Pay  
\_\_\_\_\_ Deny  
\_\_\_\_\_ Recoup

## Instructions for Completing the Adjustment Request Form:

Field Name and Number	Instructions for Completion
1. Provider Number	Enter the 9-digit Arkansas Medicaid provider number under which payment is to be made.
2. Provider Name and Address	Complete this field with the same information with which you bill Medicaid.
3. Overpayment (Credit)	If duplicate payments, incorrect payments or overpayments are made, submit an adjustment request and check the box labeled overpayment. EDS will withhold (recoup) the overpayment amount from future claims payments.
4. Underpayment (Debit)	If a claim is underpaid, check the box labeled underpayment to have the correct amount added to future claims payments.
5. Informational Corrections	Check this box if the claim paid the correct amount using incorrect information, such as the wrong dates of service. This box should be checked only if it will not affect the amount paid.
6. Claim Number (ICN - Internal Control Number)	Enter the 13-digit claim number exactly as it is printed on your RA.
7. Patient Name	Enter the patient's last name, first name and middle initial.
8. Recipient ID Number	Enter the entire 10-digit Medicaid recipient identification number exactly as it appears on the RA.
9. Remittance Advice Date	Enter the date of the RA, which is found at the top right corner of the RA.
10. Date(s) of Service	Enter the beginning and ending month, day and year of the services.
11. Billed Amount	Enter the amount the Medicaid Program was actually billed for the service(s).
12. Paid Amount	Enter the amount actually paid by Medicaid for the service(s) in question.
13. Description of the Problem	Indicate a specific reason for the adjustment request and the nature of the incorrect payment.
14. Signature and Date	Enter the signature of the requester and the date the adjustment request was prepared.