Rhode Island Executive Office of Health and Human Services
Medicaid Program
Claim *Recoupment* Request

gɑɪnwell

ALL FIELDS ARE MANDATORY - *the claim recoupment request form will be returned to the provider if incomplete. Claim type must be same for all.*

Provider Name			Provider NPI			
Mailing Address	No./Street		City		State	Zip

ICN (15 characters)	Detail Number(s)*	Recipient Medicaid ID	From DOS**	To DOS**	Recoupment Reason Code
123456789123456	*3*	*1000123456*	*01 / 01 /2016*	*02 / 01 / 2016*	*054*

*Please enter "ALL" if the request is to recoup the ENTIRE claim.

Applicable Recoupment Reason Codes

Reason Code	Reason Code Description	Reason Code	Reason Code Description
019	Client covered through Rite Care/Share	052	Provider wrong units of service
020	Wrong dates of service	053	Provider wrong submitted charge
021	Wrong patient status	054	Provider wrong TPL payment
026	Adjusted wrong tooth number/surface	055	Provider duplicate payment
027	Recoup script cancelled/refused, not picked up	066	Client did not receive service
029	Incorrect Medicare paid amount, co-ins/deductible	067	Change in recipient eligibility
048	Provider wrong provider number	068	Recipient has Medicare coverage
049	Provider wrong recipient number	069	Recipient has verified other insurance
050	Provider Wrong Proc/Drug code	118	Auto Insurance paid claim
051	Provider wrong procedure modifier	121	Claim paid by attorney

**Recoupments for dates-of-service >365 days are not allowed when a new claim will be submitted for increased reimbursement without a primary payer EOB dated within 90 days.

Print, sign and mail to:

RI MEDICAID PROGRAM • Gainwell Technologies • P.O. BOX 2010 • WARWICK, RI 02887-2010

Requestor (Print Name):	Title:
Provider/Authorized Agent Signature:	Gainwell Use Only
	Gainwell Examiner:
Date:	Date:

PR0061 1.4 01/25/2021

Claims can be voided electronically if submitted within one calendar year. This process makes corrections and resubmissions quick and easy. Please contact your provider representative for more information.