



Claim Adjustment Request Form

ALL FIELDS ARE MANDATORY - *the claim adjustment 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 *	Recipient Medicaid ID	From DOS*	To DOS*	Adjustment Reason Code	Claim Field Update/Change		
123456789123456	3	1000555555	01 / 01 / 2016	01 / 01 / 2016	054	Change TPL payment amount to \$100.00		

*Please enter "ALL" if request is to adjust entire claim. **Applicable Adjustment Reason Codes**

Reason Code	Financial Reason Code Description	Reason Code	Financial Reason Code Description
020	Wrong dates of service	054**	Provider wrong TPL payment**
021	Wrong patient status	065	Drug unit dose adjustment
026	Adjusted wrong tooth number/surface	067	Change in recipient eligibility
029	Incorrect Medicare paid amount, co-ins/deductible	068	Recipient has Medicare coverage
050	Provider Wrong Proc/Drug code	069	Recipient has verified other insurance
051	Provider wrong procedure modifier	070	Provider Change in Ownership
052	Provider wrong units of service	087	Adjust Wrong Units and Billed Amount
053	Provider wrong submitted charge	160	Retro rate, liability change

*Adjustments 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.

**Must attach primary payer explanation of benefits for Adjustment Reason Code 054

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:

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