**MARYLAND MEDICAL ASSISTANCE PROGRAM**

**MULTIPLE CLAIM ADJUSTMENT REQUEST FORM**

**Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**.**

**Total Check Amt. \_\_\_\_\_\_\_\_\_\_\_\_**

**Check No. \_\_\_\_\_\_\_\_\_\_\_ Check Date \_\_\_\_\_\_\_\_\_\_\_**

**Tel. No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Adjustment Reason Codes:**

1. Incorrect Procedure
2. Incorrect Units of Service
3. Incorrect Modifier
4. Incorrect $ Amt. Charged
5. Wrong Provider Paid
6. Duplicate Payment
7. Other Insurance Paid
8. Outpatient Adm. Hos.

09. Recovery from Attorney  
11. TPL Payment Wrong

1. Recipient did not Receive Services
2. Change in Recipient Eligibility
3. Change in Patient Resource

**BR Change In Preauthorization**

**CG Incorrect Date of Service**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Invoice Control Number** | **Recipient I.D. Number** | | **Date of Service** | **Adj. Rsn Code** | **Refund $ Amt** |
| **1.** |  | |  |  |  |
| **2.** |  | |  |  |  |
| **3.** |  | |  |  |  |
| **4.** |  | |  |  |  |
| **5.** |  | |  |  |  |
| **6.** |  | |  |  |  |
| **7.** |  | |  |  |  |
| **8.** |  | |  |  |  |
| **9.** |  | |  |  |  |
| **10.** |  | |  |  |  |
| **11.** |  | |  |  |  |
| **12.** |  | |  |  |  |
| **13.** |  | |  |  |  |
| **14.** |  | |  |  |  |
| **15.** |  | |  |  |  |
| **16.** |  | |  |  |  |
| **17.** |  | |  |  |  |
| **18.** |  | |  |  |  |
| **19.** |  | |  |  |  |
| **20.** |  | |  |  |  |
| **Name of Provider Representative:** | **Date:** | **ICN:** | | | |

**DHMH 4567A 10/00 This form is to be sent to the Adjustment Section, Medical Care Program Adm., P.O. Box 13045. Baltimore. MD 21203 410-767-5346**