



## INSTRUCTIONS FOR COMPLETION OF THE ADJUSTMENT / VOID REQUEST FORM

ATTACH A COPY OF THE CLAIM TO BE ADJUSTED/VOIDED.

ATTACH A COPY OF THE REMITTANCE ADVICE PAGE THAT REFLECTS THE PAYMENT OF THE CLAIM TO BE ADJUSTED/VOIDED.

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### PART I PROVIDER INFORMATION

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1. PROVIDER NAME AND ADDRESS - ENTER THE NAME AND ADDRESS OF THE PROVIDER WHO RENDERED THE SERVICE.
2. BILLING PROVIDER NUMBER - ENTER THE ALASKA MEDICAID PROVIDER NUMBER IF THE PROVIDER PAID FOR THE SERVICE (BILLING PROVIDER). IF THE CLAIM WAS PAID UNDER AN INCORRECT PROVIDER NUMBER, IT MUST BE VOIDED AND A NEW CLAIM SUBMITTED.
3. RENDERING PROVIDER NUMBER - IF THE PROVIDER WHO RENDERED THE SERVICE IS DIFFERENT FROM THE PROVIDER WHO WAS PAID FOR THE SERVICE (#2), ENTER THE RENDERING PROVIDER'S ALASKA MEDICAID NUMBER. IF THE CLAIM WAS PAID UNDER AN INCORRECT RENDERING PROVIDER NUMBER, IT MUST BE VOIDED AND A NEW CLAIM SUBMITTED.
4. OVERPAYMENT - IF AN ADJUSTMENT/VOID RESULTS IN MONEY OWED TO THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES, HEALTH CARE PROFESSIONALS HAVE THE OPTION TO EITHER REFUND THE MONEY OR REQUEST THAT THE MONEY BE RECOVERED FROM FUTURE PAYMENT OF APPROVED CLAIMS. IF NO CHECK IS ENCLOSED, THE MONEY WILL BE RECOVERED FROM A FUTURE REMITTANCE ADVICE. HEALTH CARE PROFESSIONALS WHO ATTACH A REFUND CHECK TO THE ADJUSTMENT/VOID REQUEST ARE TO INDICATE THE AMOUNT OF THE OVERPAYMENT AND THEIR REFUND CHECK NUMBER. MAKE THE CHECK PAYABLE TO "STATE OF ALASKA."

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### PART II CLAIM INFORMATION

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5. RECIPIENT NAME - ENTER THE RECIPIENT'S NAME AS IT APPEARS ON THE REMITTANCE ADVICE. IF THE PAYMENT WAS MADE FOR THE WRONG RECIPIENT, THE CLAIM MUST BE VOIDED AND A NEW CLAIM SUBMITTED.
6. RECIPIENT NUMBER - ENTER THE RECIPIENT'S NUMBER AS IT APPEARS ON THE REMITTANCE ADVICE. IF THE PAYMENT WAS MADE FOR THE WRONG RECIPIENT, THE CLAIM MUST BE VOIDED AND A NEW CLAIM SUBMITTED.
- 7A. CLAIM CONTROL NUMBER - ENTER THE FIRST ELEVEN (11) DIGITS OF THE CCN AS IT APPEARS ON THE REMITTANCE ADVICE.
- 7B. LINE NUMBER - ENTER THE LAST TWO DIGITS OF THE CCN FOR EACH CLAIM LINE TO BE ADJUSTED/VOIDED (PROVIDERS BILLING ON THE UB-92 CLAIM FORM SHOULD NOT LIST THE LINE NUMBER IN THIS FIELD). THE CLAIM LINE NUMBER ON ALL CLAIMS OTHER THAN THE UB-92 APPEARS IN THE FIRST COLUMN OF THE REMITTANCE ADVICE AND IS DIFFERENT FOR EACH SERVICE BILLED THAT HAS THE SAME FIRST ELEVEN DIGITS IN 7A.
- 7C. REASON FOR REQUEST - HEALTH CARE PROFESSIONALS ARE TO FURNISH SUFFICIENT INFORMATION TO PROPERLY PROCESS THE ADJUSTMENT/VOID REQUEST AND ATTACH SUPPORTING DOCUMENTATION TO SUPPORT THE REQUEST.  
  
EXAMPLE 1 - LINE 03 WAS BILLED WITH A \$10.00 CHARGE FOR THE SERVICE. ADJUST THE CLAIM TO REFLECT A \$15.00 BILLED CHARGE.  
EXAMPLE 2 - PAYMENT WAS RECEIVED FOR A SERVICE THAT WAS NOT RENDERED BY THIS PROVIDER. VOID THE CLAIM.  
EXAMPLE 3 - THIRD PARTY INSURANCE PAID \$15.00 FOR THE LINE NUMBERS 01, 02, AND 04.
- 7D. COMMENTS - PLACE ANY ADDITIONAL COMMENTS WHICH MAY FACILITATE PROCESSING THE ADJUSTMENT/VOID.
8. SIGNATURE - THE ADJUSTMENT/VOID FORM MUST HAVE AN ORIGINAL SIGNATURE OF THE PROVIDER OR HIS/HER AUTHORIZED REPRESENTATIVE.

DATE - ENTER THE DATE THE ADJUSTMENT/VOID IS SUBMITTED.

**NOTE - ALL POSITIVE ADJUSTMENTS (ADJUSTMENTS THAT WILL RESULT IN ADDITIONAL MONEY PAID FOR THE CLAIM) MUST BE SUBMITTED WITHIN ONE (1) YEAR FROM DATE OF SERVICE OR SIXTY (60) DAYS FROM THE PAYMENT DATE.**

**MAIL COMPLETED ADJUSTMENT / VOID FORMS TO THE FOLLOWING ADDRESS:**

**AFFILIATED COMPUTER SERVICES, INC.**  
P.O. BOX 240807  
ANCHORAGE, ALASKA 99524-0807



A xerox Company

AFFILIATED COMPUTER SERVICES, INC.
PROVIDER INQUIRY FOR THE FAX (907) 644-8126
CHECK AMOUNT CLAIM STATUS

Date

Provider: Medicaid Contract ID+ NPI++ Provider Name
Contact Person Provider Fax Provider Phone

Nature of Inquiry: [ ] Check Amount [ ] Claim Status

ACS Response: Check Amount: \$ Current RA Date:

For claim status inquiries, please provide the information below (Medicaid number, recipient name, date of service, et cetera):

1. (Medicaid Number) (Recipient Name) (Date of service) (Procedure code) (Modifier) (Billed Amount)

ACS RESPONSE:

2. (Medicaid Number) (Recipient Name) (Date of service) (Procedure code) (Modifier) (Billed Amount)

ACS RESPONSE:

3. (Medicaid Number) (Recipient Name) (Date of service) (Procedure code) (Modifier) (Billed Amount)

ACS RESPONSE:

4. (Medicaid Number) (Recipient Name) (Date of service) (Procedure code) (Modifier) (Billed Amount)

ACS RESPONSE:

5. (Medicaid Number) (Recipient Name) (Date of service) (Procedure code) (Modifier) (Billed Amount)

ACS RESPONSE:

COMPLETED BY (ACS Provider Inquiry Specialist) (Date)

\* Formerly known as Alaska Medical Assistance Provider Number

\*\* National Provider Identifier