# Medicaid Adjustment Request Form (ADJ-02)

Mail to: Adjustments
P.O. Box 241684
Montgomery, AL 36121-1684

## Section I: Provider Pay-To Information

NPI Number _____

Provider Name _____

Address _____

_____

- ☐ Overpayment: Please process to correct the overpayment
- ☐ Underpayment: Please process to correct the underpayment
- ☐ Information correction: Please process to reflect the correct information

## Section II: Paid Claims Information

Please enter the following data from your remittance advice:

ICN Number: _____

Recipient ID Number: _____

Date(s) of Service: _____

Billed Amount: _____

Recipient Name: _____

EOP Date: _____

Paid Amount: _____

## Section III: Description of the Problem

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

## HPE Use Only

Date of Adjustment: _____

Reviewer: _____

Adjustment action:

_____ Pay

_____ Recoup

Revised 01-06-16