



CLAIM ADJUSTMENT FORM

Mail to:
 Children's Mercy Family Health Partners
 PO Box 411806
 Kansas City, MO 64141-1806

Please check which Medicaid Plan this affect:

Kansas Medicaid – HealthWave

Missouri Medicaid – MO HealthNet

To Facilitate Processing, You Must Attach the Following Information:

- 1. Corrected claim copy
- 2. Remittance Advice copy

Date Requested: _____

Contact Name: _____

Phone Number: _____

Section I – Billing Provider

Billing Provider Name:

NPI Number:

Section II – Member and Claim Information

Member Name:

Member ID Number:

Form Number:

Date of Service:

Check Number and Date:

Total Billed Amount:

Section III – Adjustment Information – Identify the issue to resolve

- Claim Recoupment or Adjustment**
- Duplicate Payment
 - Not your patient
 - Corrected bill attached
 - Under or Over Paid (please circle which applies)
 - Other: _____

Remarks:

- Refund**
- Check Attached
 - Need written request
- Reason for Refund**
- Duplicate Payment
 - Not your patient
 - Overpaid due to _____
 - Other: _____

Remarks:

Timely Filing
 Timely filing documentation must be attached which includes proof of initial submission within 180 days of date of service and either second submission or followup within the same 180 days of date of service

Other Issues:

Remarks



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