Ohio Department of Medicaid

ADJUSTMENT REQUEST FORM ODM 06767

***REMITTANCE ADVICE MUST BE ATTACHED**

1. **PROVIDER NAME**

PROVIDER ADDRESS

(CITY, ZIP CODE)

PAY TO GROUP PROVIDER NUMBER (7 DIGITS)

NATIONAL PROVIDERS IDENTIFIER (10 DIGITS)

2. **CHECK ONE:**

☐ an initial request

☐ a follow-up request

3. **Mailing Address:**

Ohio Department of Medicaid
Adjustment Unit
P.O. Box 309
Columbus, Ohio 43216-0309

4. **CLAIM TYPE:**

☐ CLINIC ☐ INDEPENDENT LAB
☐ HOME HEALTH ☐ PHYSICIANS
☐ EPSDT ☐ MEDICAL SUPPLIES
☐ DENTAL ☐ VISION
☐ AMBULANCE
☐ OTHER

5. **TOTAL NUMBER OF CLAIMS:**

6. **CHECK ONE:** ☐ Medicare Crossover ☐ Medicaid

RECIPIENT INFORMATION

7.	**A. RECIPIENT NAME** *(LAST, FIRST, INITIAL)*		**B. DATE OF SERVICES** (beginning) to (ending)	**C. RECIPIENT ID#**		**D. Transaction Control Number**		**E. Prior Authorization**
	F. Incorrect Code/Units/Modifier	**G. Correct Code/Units/Modifier**	**H. Reason for Refund** ☐ Private Insurance ☐ Other	**I. Check Number**	**J. Check Amount**	**K. Amt. Refunded for Rec.**	**L. Medicaid Paid**	**M.** ☐ ATTACHMENTS
8.	**A. RECIPIENT NAME** *(LAST, FIRST, INITIAL)*		**B. DATE OF SERVICES** (beginning) to (ending)	**C. RECIPIENT ID#**		**D. Transaction Control Number**		**E. Prior Authorization**
	F. Incorrect Code/Units/Modifier	**G. Correct Code/Units/Modifier**	**H. Reason for Refund** ☐ Private Insurance ☐ Other	**I. Check Number**	**J. Check Amount**	**K. Amt. Refunded for Rec.**	**L. Medicaid Paid**	**M.** ☐ ATTACHMENTS
9.	**A. RECIPIENT NAME** *(LAST, FIRST, INITIAL)*		**B. DATE OF SERVICES** (beginning) to (ending)	**C. RECIPIENT ID#**		**D. Transaction Control Number**		**E. Prior Authorization**
	F. Incorrect Code/Units/Modifier	**G. Correct Code/Units/Modifier**	**H. Reason for Refund** ☐ Private Insurance ☐ Other	**I. Check Number**	**J. Check Amount**	**K. Amt. Refunded for Rec.**	**L. Medicaid Paid**	**M.** ☐ ATTACHMENTS
10.	**A. RECIPIENT NAME** *(LAST, FIRST, INITIAL)*		**B. DATE OF SERVICES** (beginning) to (ending)	**C. RECIPIENT ID#**		**D. Transaction Control Number**		**E. Prior Authorization**
	F. Incorrect Code/Units/Modifier	**G. Correct Code/Units/Modifier**	**H. Reason for Refund** ☐ Private Insurance ☐ Other	**I. Check Number**	**J. Check Amount**	**K. Amt. Refunded for Rec.**	**L. Medicaid Paid**	**M.** ☐ ATTACHMENTS
11.	**A. RECIPIENT NAME** *(LAST, FIRST, INITIAL)*		**B. DATE OF SERVICES** (beginning) to (ending)	**C. RECIPIENT ID#**		**D. Transaction Control Number**		**E. Prior Authorization**
	F. Incorrect Code/Units/Modifier	**G. Correct Code/Units/Modifier**	**H. Reason for Refund** ☐ Private Insurance ☐ Other	**I. Check Number**	**J. Check Amount**	**K. Amt. Refunded for Rec.**	**L. Medicaid Paid**	**M.** ☐ ATTACHMENTS
12.	**A. RECIPIENT NAME** *(LAST, FIRST, INITIAL)*		**B. DATE OF SERVICES** (beginning) to (ending)	**C. RECIPIENT ID#**		**D. Transaction Control Number**		**E. Prior Authorization**
	F. Incorrect Code/Units/Modifier	**G. Correct Code/Units/Modifier**	**H. Reason for Refund** ☐ Private Insurance ☐ Other	**I. Check Number**	**J. Check Amount**	**K. Amt. Refunded for Rec.**	**L. Medicaid Paid**	**M.** ☐ ATTACHMENTS

DEPARTMENTAL USE ONLY	
Trans. #	
Type	ACCT. CODE
MMIS CODE	RSN
DATE UPDATED	INITIALS

13. **REMARKS:**

SIGNATURE OF PROVIDER REPRESENTATIVE	**TELEPHONE NUMBER:**	**DATE:**

ADJ. REQUEST/CORRESPONDENCE (with supporting documentation, original, and one copy of form) to: Ohio Department of Medicaid, Claims Adjustment Unit, P.O. Box 309 Columbus, Ohio 43216-0309 (telephone 614-466-5080) Instructions to return overpayments can be found on the following Medicaid Web Link: Provider e-manuals---http://Medicaid.Ohio.gov/providers.aspx.

INSTRUCTIONS FOR COMPLETING THE ADJUSTMENT REQUEST FROM JFS 06767

1. **Provider Name:** Enter the name of the provider who actually received the Medicaid payment.

   Provider Address - Enter the complete mailing address; including city, state and zip code, of the provider who received the Medicaid payment.

   Provider Number - Enter the seven (7) digit Medicaid Provider number assigned to the individual provider who received the Medicaid payment. This must be completed for an adjustment to occur.

   National Provider Identifier Number – Enter the ten (10)-digit NPI number. The NPI and Provider number will ensure appropriate processing of claims.

2. **Check One -** All adjustment requests on each JFS 06767 must be either an initial request or follow-up request:

   An Initial Request - Check “initial request” if a JFS 06767 has not previously been submitted for the payment(s) in question.

   A Follow-Up Request - If a request has been previously submitted check the “follow-up request" block in **red** on a photostatic copy of the original JFS 06767. Do not complete a second JFS 06767.

3. **Adjust Request/Correspondence (with supporting documentation, original, and one copy) - Ohio Department of Medicaid, Adjustment Unit, P.O. Box 309, Columbus, Ohio 43216-0309.**

4. **Claim Type:** Check the type of claim(s) originally submitted. If adjustments are to be requested for more than one type of claim. separate request forms must be submitted.

5. **Total Number of Claims:** Enter the total number of claims included in the request. If the total is more than six (6) claims, additional request forms must be submitted with the total number of claims involved entered on each form. Example: A request for 18 claims adjustments would require three (3) forms and the number 18 would be entered in this block of each form.

6. **Check One:** Check the appropriate block to indicate whether the request involves either Medicare Crossover or Medicaid Claims. Do not include both types on the same submission.

7. **7 - 12 "A" through "M":** (Recipient Information)

   A. **Recipient Name -** Enter the name of the recipient who actually received the service. Enter last name first.

   B. **Dates of Service -** Enter the six (6) digit dates of service (MM/DD/YY) in chronological order (first to last). Enter all six characters consecutively with slashes; example: 010788 = 01/07/88.

   C. **Recipient IDM -** Enter the ten (10) digit case number followed by the two (2) digit recipient number as printed on the Medicaid card. The recipient number can be found in the block marked "ADC number" on the Ohio Medicaid card.

   D. **Transaction Control Number -** Enter the transaction control number (TCN) in question as it appears on the remittance advice.

   E. **Prior Authorization -** Complete only if Prior Authorization was required for the services billed. Enter the six (6) digit number from the Prior Authorization form (JFS 03142 or JFS 03612) which authorized the procedure.

   F. **Incorrect Code/Unit(s)/Modifier -** Enter the **incorrect code,** unit(s), or modifier as they appear on the Remittance Advice. If the code, unit(s), or modifier is correct, leave this and the following space blank.

   G. **Correct Code/Unit(s)/Modifier -** If the original code, unit(s) or modifier of service was incorrect, enter the correct code, unit(s) or modifier.

   H. **Reason for Refund -** Complete this item if more than one check is enclosed with the request. Check either the "Private Insurance” or "Other" block; depending on the source of Third Party payment (Please see Item 3 above for exceptions).

   I. **Check Number -** If more than one check is enclosed, enter the number of the check applicable to the specific recipient.

   J. **Check Amount -** If more than one check is enclosed, enter the total amount applicable to the specific recipient.

   K. **Amount Refunded for Recipient -** Complete if a single check is enclosed. Enter the portion of the check amount which is being refunded for the specific recipient and service. (Please see Item 3 above for exceptions).

   L. **Medicaid Paid -** Enter the amount paid by Medicaid for the specific recipient, as it appears on the Remittance Advice.

   M. **Attachments -** Check this block if document(s) relating to the request are included in the information sent. (Example: Prior Authorization forms, a Remittance Advice with a different pay date showing duplication).

   Remarks: Complete this section to explain “other” reason for refund (H) using items 7 - 12 for reference. if appropriate, or when requesting additional payment. Further clarification of the error to be corrected may also be included in this section. The name and work phone of the person who should be contacted with regards to the payment in question should be included, if different from the person completing the form.

   Signature, Telephone Number, Date - Enter the signature of the Provider representative responsible for completing the form, the telephone number (including area code) where they may be reached, and the date the form was completed.