# Individual Adjustment Request

*To facilitate processing, attach the following:*

- Claim copy
- Remittance advice copy

☐ Total claim recoupment
☐ Claim adjustment

☐ Underpayment
☐ Overpayment
(Do not send a check with the adjustment.)

## Section I – Billing and Beneficiary Information

| | |
|---|---|
| **1.** Name – Billing Provider<br>. | **2.** Billing Provider's KMAP Provider ID |
| **3.** Name – Beneficiary | **4.** Beneficiary's ID Number |
| | **5.** NPI |

## Section II – Claim Information

| | |
|---|---|
| **6.** Internal Control Number | **7.** Remittance Advice Date |

## Section III – Adjustment Detail Information (Enter corrected information only.)

| **8.** Claim detail(s) Delete | Add | **9.** Claim detail to be adjusted | **10.** Date(s) of service From | To | **11.** POS | **12.** Procedure/NDC/ revenue code | **13.** Modifiers 1-4 | | | | **14.** Billed amount | **15.** Units/qty. | **16.** Performing provider | **17.** NPI |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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| | | | | | | | | | | | | | | |
| **18.** Third-party liability (TPL) - Attach explanation of benefits. | | | | | | | | | | | | | | |
| **19.** Remarks section | | | | | | | | | | | | | | |

☐ Attachment(s) with adjustment

Contact name: _____

Contact phone number: _____

Send to:
Office of the Fiscal Agent
Attn: Adjustment Department
PO Box 3571
Topeka, KS 66601-3571
Fax: 785-274-4296

**20.** Provider signature: _____

**21.** Date: _____



*Revised 08.2017*

## Completing the Individual Adjustment Request

**To facilitate processing, attach the following:**

- **Claim copy** – Attach a corrected claim to this form.
- **Remittance advice copy** – Attach a copy of the most current remittance advice (RA) of claim being adjusted.

**Adjustment Type Checkboxes**

**Total claim recoupment** – Check this box if the request is for a full claim recoupment.

**Claim adjustment** – Check this box if the request is for a previously paid claim that requires changes.

**Underpayment** – Check this box if the claim was underpaid.

**Overpayment** – Check this box if the claim was overpaid. Do not send a check.

**Section I – Billing Provider and Beneficiary Information (Required)**

Field 1 **Name – Billing Provider** – Enter the billing provider name.

Field 2 **Billing Provider's KMAP Provider ID** – Enter the billing provider's nine-digit identification number (ID) and alpha location character.

Field 3 **Name – Beneficiary** – Enter the beneficiary's name as it appears on the medical card.

Field 4 **Beneficiary's ID Number** – Enter the beneficiary's 11-digit ID number.

***Note:*** This number can be found in Column 2 of the RA.

Field 5 **NPI** – Enter the billing provider's national provider identifier (NPI).

**Section II – Claim Information (Required)**

Field 6 **Internal Control Number** – Enter the 13-digit claim number to be adjusted or recouped.

***Note:*** This number can be found in Column 4 of the RA.

Field 7 **Remittance Advice Date** – Enter the RA date for the claim number indicated in Field 6.

**Section III – Adjusted Detail Information (Indicate only adjusted information.)**

Field 8 **Claim detail(s)** –

**Delete** – Check this box if the original detail is to be deleted on the adjusted claim.

**Add** – Check this box if this detail is to be added to the adjusted claim. Enter new detail information in Fields 9-17.

***Note:*** If the detail exists on the original claim and detail information needs to be changed, do not check these boxes. Indicate changed information accordingly in Fields 9-17.

Field 9 **Claim detail to be adjusted** – Indicate the original line detail to be changed.

Field 10 **Date(s) of service** – Enter the **From** and **To** date if they need to be changed for the detail line.

Field 11 **POS** – Enter the appropriate two-digit place of service code if detail requires change.

Field 12 **Procedure/NDC/revenue code** – Enter the single most appropriate code to be changed.

Field 13 **Modifiers 1-4** – Enter the modifiers to be changed.

Field 14 **Billed amount** – Enter the changed billed amount for the detail line.

Field 15 **Unit quantity** – Enter the appropriate number of units for each detail line to be changed. Always use a decimal (for example, 2.0 units).

Field 16 **Performing provider** – Enter the performing provider's KMAP nine-digit number and alpha location character to be changed.

Field 17 **NPI** – Enter the performing provider's NPI to be changed.

Field 18 **Third-party liability (TPL)** – Attach explanation of benefits (EOB). Indicate primary insurance and/or Medicare in this field and attach appropriate EOB or explanation of Medicare benefits (EOMB) to adjustment form.

Field 19 **Remarks section** – Enter any additional remarks in this field.
***Note:*** Dental providers – Enter the tooth number and surface code in the Remarks section.

**Attachments with adjustment** – Check this box if attachments were submitted with the adjustment form.

**Contact name** – Indicate an office contact name for questions regarding this adjustment.

**Contact phone number** – Indicate the office contact phone number for questions regarding this adjustment.

Field 20 **Provider signature** – Authorized signature of the provider.

Field 21 **Date** – Enter the signature date.

***Notes:***

If additional space is needed, use the Multiple Adjustment Request form.

Retain a copy of the adjustment for your files.

This form can be obtained from the KMAP website at https://www.kmap-state-ks.us.

This form can be faxed or postage mailed to the Adjustment department.

Adjustments resulting in an overpayment are deducted from future RAs.

**Nursing facility providers**

If you need to correct information on an ICN that has been paid or has an allowed amount present, submit the corrected information on an Individual Adjustment Request form.

**Hospital claims**

If a hospital stay is denied as inappropriate based on an inpatient utilization review contractor, recoupment of collateral claims will be pursued from the admitting physician only. Other ancillary claims will not be recouped.

**Submission of the Individual Adjustment Request**

Mail or fax to:

Office of the Fiscal Agent
Attn: Adjustment Department
PO Box 3571
Topeka, Kansas 66601-3571
Fax: 785-274-4296