Multiple Adjustment Request Form

Mark only one:
Total Recoupment_____
Claim Adjustment_____

Billing Provider Name: _____ Billing Provider NPI: _____ Contact Information: _____

	Provider KMAP ID	ICN	Detail #	From DOS	Last DOS	Beneficiary ID	Requested Change
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							

Mail to:
Kansas Medical Assistance Program Attn: Adjustment Unit
P.O. Box 3571
Topeka, KS 66601

Revised Date: 12/10/2012

Fax: (785) 274-4296

Instructions for Completing the Multiple Adjustment Request

The Multiple Adjustment Request form is to be used when requesting multiple adjustments for the same or similar reasons. The adjustments could be due to an internal review, billing error, and so forth. On a separate piece of paper, include a detailed description of the specific reason for the adjustments. Return it with the form to aid in processing. The information requested on the form can be found on the remittance advice associated with the claim. The following fields are required to process the adjustment requests:

Billing Provider Name – Enter the billing provider name.

Billing Provider NPI – Enter the billing provider's 10-digit National Provider Identifier (NPI).

Contact Information – Enter an office contact name and telephone number for questions.

Type of Request – Indicate whether your request is for a total recoupment or claim adjustment. Only mark the Total Recoupment line if you are expecting the entire claim to be recouped. For anything other than a total claim recoupment, mark the Claim Adjustment line.

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

ICN – Enter the 13-digit claim number to be adjusted or recouped.

Detail # – Enter the original line detail to be adjusted.

From DOS – Enter the original from date of service (DOS) for the detail to be adjusted.

Last DOS – Enter the original last DOS for the detail to be adjusted.

Beneficiary ID – Enter the beneficiary's 11-digit ID number from the original claim.

Requested Change – Enter the information on the claim to be changed. For example, if the procedure code is to be changed, enter the new procedure code in this field. If other insurance made a payment, indicate the amount of the payment.

Refer to Section 5600 of the *General Billing Provider Manual* for more information.
Your request could be returned for the following reasons:

- Requested changes are not clear.
- All fields are not completed.
- Spreadsheet is altered, such as columns were removed or added.

To submit, send to the following:

Office of the Fiscal Agent
Attn: Adjustment Department
P.O. Box 3571
Topeka, KS 66601 Fax: 785-274-4296