IHCP Institutional and Inpatient/Outpatient Crossover Adjustment Request

Indiana Family and Social Services Administration

Mail completed requests to Gainwell – Adjustments, P.O. Box 7265, Indianapolis, IN 46207-7265

1. Provider NPI IHCP Provider ID Provider name/address/ZIP Code+4: Taxonomy code Telephone number Contact name	2. Reason for adjustment (check appropriate box) ☐ Change third-party liability (TPL) amount ☐ Change patient-deductible amount ☐ Offset or refund of entire claim amount (check field 9) ☐ Change information as indicated in fields 13–17 ☐ Medicare adjustment (attach all EOMBs that apply to this adjustment)

3. Claim ID (ICN)	4. Member ID	5. Dates of service From Through
6. Member name	7. Amount paid	8. Remittance Advice date

9. Type of adjustment	10. Claim type
☐ Underpayment adjustment ☐ Overpayment adjustment (deduct from future payments) ☐ Refund adjustment (check attached) Check number:	☐ Inpatient ☐ Outpatient ☐ Long-term care ☐ Home health ☐ Crossover institutional (inpatient or outpatient)

11. Provider NPI/taxonomy

Attending NPI	Operating NPI
Attending Taxonomy	Other NPI

12. Give complete explanation of adjustment or refund request:

Please list the information to be corrected in the fields below. If no line number is associated with the correction, please enter a zero (0) in the line number field. For example, TPL applied is always line # 0.

13. Line No.	14. Rev/Proc code	15. Description of information to be corrected	16. Current information	17. Corrected information

18. Signature _____ 19. Date _____

IHCP Institutional and Inpatient/Outpatient Crossover Adjustment Request Instructions

A completed adjustment request form is required for each claim to be adjusted. In addition, copies of the Remittance Advice (RA) and the corrected claim will facilitate the adjustment process but are not required documents.

- For outpatient claims, if another insurance carrier, including Medicare, was billed for the service, also include a completed *IHCP Third-Party Liability (TPL)/Medicare Special Attachment Form* with detail-level information.
- If the adjustment request is for a crossover claim, please attach a copy of the *Explanation of Medicare Benefits*.

1.	Provider NPI or Provider ID	Enter the IHCP Provider ID (atypical providers) or a 10-digit National Provider Identifier (NPI) for the billing provider.
	Provider name/address	Enter the current billing name, address, and ZIP Code+4.
	Taxonomy code	Enter taxonomy code for the billing provider.
	Telephone number	Enter a current telephone number for the billing provider.
	Contact name	Enter a contact name.
2.	Reason for adjustment	Check the appropriate box for the reason for the adjustment request.
3.	Claim ID (ICN)	Enter the Claim ID number (also known as the internal control number or ICN) of the claim to be adjusted. You will find the ICN on the RA. Please use the most current ICN/Claim ID for the claim to be adjusted.
4.	Member ID	Enter the member's 12-digit IHCP Member ID number (also known as RID).
5.	Dates of service	Enter the *from* and *through* dates of service, as billed on the claim.
6.	Member name	Enter the first and last name of the member.
7.	Amount paid	Enter the paid amount of the claim to be adjusted.
8.	Remittance Advice date	Enter the date of the RA on which the claim last paid.
9.	Type of adjustment	Check the appropriate box for the type of adjustment requested: • *Underpayment* – An adjustment to a claim requesting an additional payment, or requesting a change to the claim's data that results in no net change in payment. • *Overpayment* – An adjustment to a claim requesting that an overpaid amount be deducted from future payments. This can be a recoupment of a portion of the claim or the entire amount of the claim. • *Refund* – Same as overpayment except that a refund check is being submitted for the overpaid amount. A refund can be applied to a portion of the claim or to the entire amount of the claim.
10.	Claim type	Check the appropriate box of the claim type to be adjusted.
11.	Provider NPI/taxonomy	Enter NPI for attending provider. Enter the NPI for the operating and other provider.
12.	Explanation	Give a clear explanation for the requested adjustment or refund.
13.	Line no.	Include the line number on the claim where the data needs to be adjusted. If no line number is associated with the correction, please enter a zero (0) in the line number field. For example, TPL applied is always line # 0.
14.	Rev/Proc code	Enter revenue code or procedure code to be adjusted.
15.	Description of information to be corrected	Enter a brief description of the data that is to be corrected on the claim.
16.	Current information	Enter the information as stated on the current claim that is to be adjusted.
17.	Corrected information	Enter the corrected information for the claim.
18.	Signature	Include the signature of the person submitting the form, such as a physician or billing clerk.
19.	Date	Enter the date the request is submitted.