

**STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PHARMACY PAID CLAIM ADJUSTMENT REQUEST**

List no more than 10 claims per request

(1) PROVIDER NUMBER PROVIDER NAME/ADDRESS	Mail completed adjustment request forms to: OHCA – Adjustments 2401 N.W. 23rd Street, Suite 1A Oklahoma City, OK 73107 Mail Refunds to: OHCA - Finance, P.O. Box 18299, Oklahoma City, OK 73154-0299	
PHONE NUMBER: CONTACT PERSON:	(2) MEDICAID PROGRAM Fee for Service SoonerCare	(3) TYPE OF ADJUSTMENT Underpayment Adjustment Overpayment Adjustment (Deduct from future payments) Refund Adjustment (Check attached) Check number:

Complete blocks 4 – 10 for each Pharmacy claim to be adjusted. If all information is not complete, this request will be returned.

(4) CLAIM NUMBER (ICN)	(5) CLIENT ID NO.	(6) DATE DISPENSED	(7) AMOUNT PAID	(8) CURRENT INFORMATION	(9) CORRECTED INFORMATION	(10) EXPLANATION OF ADJUSTMENT

(11) SIGNATURE: _____ **(12) DATE:** _____

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PHARMACY PAID CLAIM ADJUSTMENT REQUEST INSTRUCTIONS

A completed adjustment request form is required for each claim you are requesting to be adjusted. In addition, a copy of the Remittance Advice and a copy of the corrected claim will also facilitate the adjustment process. If the adjustment request is for a Crossover claim attach a copy of the Medicare EOMB or if the request is for an adjustment to the TPL amount attach a copy of the insurance EOMB.

- 1 PROVIDER NUMBER** Enter your 9 digit billing provider number and 1 character service location
- PROVIDER NAME/ADDRESS** Enter your current billing name and address
- PHONE NUMBER** Enter phone number of contact person
- CONTACT NAME** Enter a contact name
- 2 PROGRAM** Check the appropriate box for the program to which the claim to be adjusted is associated
- 3 TYPE OF ADJUSTMENT** Check the appropriate box for the type of adjustment you are requesting:
 - * Underpayment – An adjustment to a claim in which you are requesting additional payment, or for which you are requesting a change to the claim’s data which will result in no net change in payment.
 - * Overpayment – An adjustment to a claim for which you are requesting that an overpaid amount be deducted from your future payments. (This may be a recoupment of a portion or the entire amount of the claim.)
 - * Refund – Same as overpayment except that you are submitting a refund check for the overpaid amount. (A refund may be applied to a portion of the claim or to the entire amount of the claim.)
- 4 CLAIM NUMBER (ICN)** Enter the Internal Control Number of the claim you wish to adjust. This can be found on the Remittance Advice. (use the most current ICN for the claim to be adjusted.)
- 5 CLIENT ID NO.** Enter the recipient’s 12 digit identification number
- 6 DATE DISPENSED** Enter the Dispense Date as billed on the claim
- 7 AMOUNT PAID** Enter the Paid Amount of the claim to be adjusted
- 8 CURRENT INFO** Enter the information as stated on the current claim that is to be adjusted
- 9 CORRECTED INFO** Enter the corrected information for the claim
- 10 EXPLANATION** Give a clear explanation of the requested adjustment or refund (i.e. submitted incorrect units or service, incorrect NDC, private insurance paid)
- 11 SIGNATURE** Enter signature of appropriate person (physician, billing clerk, etc. – not required)
- 12 DATE** Enter the date you are submitting this request (Required)