**AuthentiCare ADJUSTMENT / VOID REQUEST**

NEW MEXICO MEDICAID

**Must select one of the options below**

|  |  |
| --- | --- |
| **ADJUSTMENT**  Use this selection:  To make any changes to a claim that was paid incorrectly.   * Adjustment requests must be submitted within 90 days from the date of the Remit Advice (RA) form the original paid claim. * For adjustment requests exceeding 5 claims or more, send your request via email to [NM.Providers@state.nm.us](mailto:NM.Providers@state.nm.us). * Section C: Please provide the request. Examples: if the dates of service needed to be changes or units need to be adjusted by code/line. * Section C: Please indicate that you approve the update as outlined. * If Section C is not completed as required adjustment will be returned. | **VOID**  Use this selection:  For any paid claim that needs to be **fully** recouped.   * Only entire claims can be voided * Paid claims that need lines or a line voided are to be considered as an adjustment, not a void. * There is no time limit when a claim can be voided. * A claim form is not needed for a Void request * For void requests exceeding 5 claims or more, send your request via email to [NM.Providers@state.nm.us](mailto:NM.Providers@state.nm.us). |
| **ALL FIELDS BELOW**  **(SECTIONS A, B, C, D)**  **ARE REQUIRED TO BE COMPLETED IN ORDER TO PROCESS THIS REQUEST**  **INCOMPLETE FORMS WILL BE RETURNED** | |
| **SECTION A: Provider Information** | **SECTION B: Claim Information** |
| **Billing NPI (Must be 10 digits)**    OR  **Billing NM Provider ID** | **Client ID#**    **TCN (Must be 17 digits)** |
| **SECTION C: Detailed Reason for Request** | |
| . | |
| **SECTION D: Authorization** | |
| **Requestor Name**  **By signing below, I hereby certify that I am authorized to make the above request**  **Requestor Signature** | **Requestor Email**    **Requestor Phone**    **Date** |