**AuthentiCare ADJUSTMENT / VOID REQUEST**

NEW MEXICO MEDICAID

**Must select one of the options below**

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| [ ]  **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.
* 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.
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| **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** |