**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.* Must be submitted with a corrected CMS-1500, UB-04 or Dental claim form and must include red-drop out ink and legal claim notice on the back.
* Always fill out the corrected claim (replacement claim) exactly as the claim was originally filed, with the exception of the information being changed.
* Adjustment requests must be submitted within 90 days from the date of the Remit Advice (RA) form the original paid claim.
* Submitting Adjustments via the web portal can only be done for claims submitted online. *i.e. Claims that were originally submitted through the web portal (these claims are indicated by TCNs that that begin with a 9), can be adjusted via the web portal*
* For adjustment requests exceeding 5 claims or more, send your request via email to NM.Providers@state.nm.us.
 | [ ]  **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.
* Voids via web portal can only be done for online submitted claims. *i.e. Claims that were originally submitted through the web portal (these claims are indicated by TCNs that begin with a 9) can be voided via the web portal.*
* 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** |