

The Colorado Medical Assistance Program

P.O. BOX 30
DENVER, CO 80201-0030

Refund to Medicaid or Returned Warrant

Complete a form for each claim or client ID and include the following:

- 1) A copy of the Provider Claim Report (PCR) showing payment or
- 2) Medicare/TPL - A copy of the SPR

Note: **Transaction Control Number (TCN) is required; if TCN is not available the following must be submitted with form;

*Medicaid Client ID, *Billing Provider Medicaid ID Number and *Date of Service. If Claim is older than 3 years provide paid date if available.

Do not use to adjust denied claims

Provider Name												
Street Address (Address used to Return to Provider)												
City, State, Zip Code												
Telephone Number												
Return to Provider: Checks or Returned Warrants and all associated documents will be returned if all <u>required information</u> is not supplied for processing.												
You <u>must</u> include a refund check or the returned warrant with this form. No Exceptions.												
REQUIRED INFORMATION:												
**Transaction Control Number (TCN) 17 or 14 digits. Do not use to adjust denied or already voided claims.												
*If TCN is not available the following must be submitted with form:												
*Medicaid Client ID								*Billing Provider Medicaid ID Number				
*Date of Service								Provider Claim Report Date if available				
Paid Date: If Claim is older than 3 years provide claim paid date if available.												
Three-digit reason code indicating the reason for the Adjustment (required):												
<input type="checkbox"/> 406 billing error – Payment adjustment. Must include amount to be taken back: \$ _____												
<input type="checkbox"/> 412 claim credit (recovery) – This will void the entire claim and produce a take back for the entire amount.												
Date								By (Provider Signature)				
FISCAL AGENT USE ONLY												
Reply (notes) and RTP reason												
Unarchive required <input type="checkbox"/> Yes <input type="checkbox"/> No												

Directions for Completing the Form

The form must be completed correctly and legibly. **Do not use the form to adjust denied or already voided claims. This form is used to adjust paid claims only.** Read the information on the face of the form to assure proper completion. Each requires all of the following:

- A copy of the PCR showing the incorrect payment. Please highlight the claim to be adjusted on the PCR.
- A separate form for each claim or Medicaid Client ID must be submitted unless there are more than 10 claims to be adjusted or voided. If there are more than 10 claims to be adjusted or voided see next bullet for processing requirements.
- If more than 10 claims need to be adjusted or voided please phone **303-534-0109 ext. 8303** and leave contact information. An electronic document will be required with the following information; 1) TCN with refund amount for each claim or 2) Medicaid Client ID, Billing Provider Medicaid ID Number, Date of Service and Paid date if available.
- **The refund check or the returned warrant must accompany this form.**

Form Instructions:

FIELD LABEL	INSTRUCTIONS
PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER	Enter the name, address, and telephone number of the provider requesting the adjustment.
TRANSACTION CONTROL NUMBER (TCN)	Enter the 17-digit or 14 digit (Pharmacies only) TCN for the claim being adjusted exactly as it appears on the PCR.
MEDICAID CLIENT ID	Enter the client's state identification number as it appears on the Provider Claim Report (PCR).
BILLING PROVIDER MEDICAID ID NUMBER	Enter the eight-digit Medical Assistance Program provider number assigned to the billing provider.
DATE OF SERVICE	Enter the date of service as shown on the PCR.
PROVIDER CLAIM REPORT DATE	Enter the run date of the PCR if available.
PAID DATE	If claim is older than 3 years provide claim paid date if available.
THREE-DIGIT REASON CODE	Check the appropriate three-digit reason code for the adjustment.
DATE/BY	Enter the authorized signature and date signed. An adjustment represents a claim amendment and is subject to the same signature and date requirements as any claim. If the form is not signed and dated, the form and all associated documents will be returned to the provider.
FISCAL AGENT USE ONLY	DO NOT mark or write in this space. This area is used by the fiscal agent for a reply to the provider.