Date Reported: _____

Board Reporting: _____

Email: _____

Universal Provider Identifier (UPI): _____

Form Sent to: _____

Reported by: _____

Phone #: _____

Fax #: _____

Errors Apply to Fiscal Year: _____

Return Form to (if applicable): _____

Bolded items are required regardless of error reason. Additional information may be required depending on reason for error.

Provider must sign and date form before returning to the Board.

Batch #	***Client UCI#***	***Service Transaction ID***	***Start Date***	***Medicaid***	**Non-Medicaid**

Provider Representative Signature: _____ **Date:** _____

If submitting via electronic media, type name above; add electronic signature: (check box) ☐

Effective 7.1.15

ADJUSTMENT FORM

Date Reported: _____

Board Reporting: _____

Email: _____

Universal Provider Identifier (UPI): _____

Form Sent to: _____

Reported by: _____

Phone #: _____

Fax # _____

Errors Apply to Fiscal Year: _____

Return Form to (if applicable): _____

Bolded items are required regardless of error reason. Additional information may be required depending on reason for error.

Provider must sign and date form before returning to the Board.

Batch #	***Client UCI#***	***Service Transaction ID***	****Reason***	***Date of Services***	**Procedure Code Billed**	***Modifier*** **Billed**	***Modifier*** **Billed**	***Modifier*** **Billed**	***Modifier*** **Billed**	**Units Billed**	**Billed Amount Billed**

Provider Representative Signature: _____ **Date:** _____

If submitting via electronic media, type name above; add electronic signature: (check box) ☐

** Denote reason for error: wrong patient, date of service, units, procedure, modifier, 3rd party pmt/indicator, etc. using the Reason Code List*