

HP Enterprise Services

**ADJUSTMENT AND CLAIM CREDIT REQUEST FORM**

**MAIL TO:** HP Enterprise Services  
P.O. BOX 2108  
FRANKFORT, KY 40602-2108  
1-800-807-1232  
ATTN: FINANCIAL SERVICES

**NOTE:** A CLAIM CREDIT VOIDS THE CLAIM ICN FROM THE SYSTEM -- A "NEW DAY" CLAIM MAY BE SUBMITTED, IF NECESSARY. THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A CORRECTED CLAIM AND REMITTANCE ADVICE TO ADJUST A CLAIM.

<b>CHECK APPROPRIATE BOX:</b> <b>CLAIM ADJUSTMENT</b> <input type="checkbox"/> <b>CLAIM CREDIT</b> <input type="checkbox"/>		1. Original Internal Control Number (ICN)	
2. Member Name		3. Member Medicaid Number	
4. Provider Name and Address	5. Provider	6. From Date of Service	7. To Date of Service
	8. Original Billed Amount	9. Original Paid Amount	10. Remittance Advice Date

11. Please specify **WHAT** is to be adjusted on the claim. You must explain in detail in order for an adjustment specialist to understand what needs to be accomplished by adjusting the claim.

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12. Please specify the **REASON** for the adjustment or claim credit request.

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13. Signature \_\_\_\_\_

14. Date \_\_\_\_\_