DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Montana Healthcare Programs
Individual Adjustment Request

Instructions

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your remittance statement. Complete only the items in Section B that represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in the General Information for Providers manual or call Provider Relations at (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name, Address, and Telephone Number

First and Last Name

Street or P.O. Box

City State ZIP Code

Telephone Number

2. Member Name

3. Internal Control Number (ICN)

4. NPI/API

5. Member ID Number

6. Date of Payment

7. Amount of Payment $

B. Complete only the items which need to be corrected.

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed – TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature _____ **Date** _____

When the form is completed and signed, attach a copy of the remittance advice. A copy of the corrected claim is optional.
Mail to Claims, P.O. Box 8000, Helena, MT 59604, or fax to (406) 442-4402.