Adjustment/void Request Form

EXHIBIT 6.9

ADJUSTMENT/VOID REQUEST FORM

SECTION A: CHECK BOX 1a), 1b) OR 2)

☐ **1a) CLAIM ADJUSTMENT**: Attach a copy of the claim with corrections made in **BLUE ink**.

DO NOT USE HIGHLIGHTER

☐ **1b) VOID CLAIM**: Attach a copy of the claim or Remittance Advice.

Complete Sections B and C.
If attaching a check, the check should be payable to **Division of Healthcare Financing (DHCF).**

☐ **2) CANCELLATION OF THE ENTIRE REMITTANCE ADVICE.** Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances.

Complete Section C only.
Attach RA. If manual check attach the check from the DHCF or if EFT make check payable to the DHCF for the entire remit amount.

SECTION B

TO FACILITATE CLAIM ADJUSTMENT PROCESSING, PLEASE COMPLETE THE FOLLOWING:

1. 17-DIGIT TCN:

2. PAYMENT DATE:

3. 9-DIGIT PROVIDER OR 10-DIGIT NPI NUMBER:

4. PROVIDER NAME:

5. 10-DIGIT CLIENT NUMBER:

6. 10-DIGIT PA NUMBER:

7. REASON FOR ADJUSTMENT OR VOID:

SECTION C: SIGNATURE AND DATE REQUIRED

PROVIDER SIGNATURE:_____ DATE: _____

RETURN ALL REQUESTS TO:
WYOMING MEDICAID
ATTN: CLAIMS
PO BOX 547
CHEYENNE, WY 82003-0547

REMARKS/STATUS:

(FOR INTERNAL USE ONLY)

CASH CONTROL NUMBER: _____

ADJUSTED BY: _____ DATE: _____