

NEW HAMPSHIRE MEDICAID ADJUSTMENT/RECOUPMENT REQUEST

Please return to:

EDS
PO Box 2040
Concord, NH 03302-2040

Adjustment

Recoupment

1. Provider Name & Address

2. Provider Number (8 digits)

3. RA Date

4. RA Number (8 digits)

5. Patient Name (Last-First-M)

6. Medicaid ID Number (11 characters)

7. Transaction Control Number (15 digits)

Please copy the information requested in boxes 8 through 18 from the Remittance advice (RA)

8. Line Code	9. From Date	10. To Date	11. Proc/Rev Code	12. Mod (s)	13. Units	14. Billed Amount	15. Paid Amount	16. Admit Date	17. Discharge Date	18. Patient Liability

19. Reason for adjustment or recoupment

20. AL Number (EDS use only)

21. Provider Signature	22. Date
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