Ohio Department of Medicaid

ADJUSTMENT REQUEST FORM – HOSPITAL ONLY

***REMITTANCE ADVICE MUST BE ATTACHED**

1. **PROVIDER NAME**

PROVIDER ADDRESS *(STREET OR BOX NUMBER,)*

(CITY, ZIP CODE)

Pay to Group Provider Number

National Identifier Number *(10 digits)*

2. **CHECK ONE**

☐ an initial request

☐ a follow-up request

3. **Mailing Address:**

Ohio Department of Medicaid
Adjustment Unit
P.O. Box 309
Columbus, Ohio 43216-0309

4. **BILL TYPE** **5.** **SOURCE**

6. TOTAL NUMBER OF CLAIMS:

7. **CHECK ONE**

☐ Medicare Crossover ☐ Medicaid

Ref. #

8.	**A. RECIPIENT NAME** *(LAST, FIRST INITIAL)*	**B. Dates of Service (beginning) to (ending)**		**C. Recipient ID #** *(12 digits)*	**D. Transaction Control Number** *(17 digits)*							**E. Medical Rec. #**
	F. PRINCIPAL DIAGNOSIS CODE	**OTHER DIAGNOSES CODES**				**K. PRINCIPAL PROCEDURE CODE**	**OTHER PROCEDURE CODES**					**P. Amt. Refunded for Rec.**
		G.	**H.**	**I.**	**J.**		**L.**	**M.**	**N.**	**O.**		
9.	**A. RECIPIENT NAME** *(LAST, FIRST INITIAL)*	**B. Dates of Service (beginning) to (ending)**		**C. Recipient ID #** *(12 digits)*	**D. Transaction Control Number** *(17 digits)*							**E. Medical Rec. #**
	F. PRINCIPAL DIAGNOSIS CODE	**OTHER DIAGNOSES CODES**				**K. PRINCIPAL PROCEDURE CODE**	**OTHER PROCEDURE CODES**					**P. Amt. Refunded for Rec.**
		G.	**H.**	**I.**	**J.**		**L.**	**M.**	**N.**	**O.**		
10.	**A. RECIPIENT NAME** *(LAST, FIRST INITIAL)*	**B. Dates of Service (beginning) to (ending)**		**C. Recipient ID #** *(12 digits)*	**D. Transaction Control Number** *(17 digits)*							**E. Medical Rec. #**
	F. PRINCIPAL DIAGNOSIS CODE	**OTHER DIAGNOSES CODES**				**K. PRINCIPAL PROCEDURE CODE**	**OTHER PROCEDURE CODES**					**P. Amt. Refunded for Rec.**
		G.	**H.**	**I.**	**J.**		**L.**	**M.**	**N.**	**O.**		
11.	**A. RECIPIENT NAME** *(LAST, FIRST INITIAL)*	**B. Dates of Service (beginning) to (ending)**		**C. Recipient ID #** *(12 digits)*	**D. Transaction Control Number** *(17 digits)*							**E. Medical Rec. #**
	F. PRINCIPAL DIAGNOSIS CODE	**OTHER DIAGNOSES CODES**				**K. PRINCIPAL PROCEDURE CODE**	**OTHER PROCEDURE CODES**					**P. Amt. Refunded for Rec.**
		G.	**H.**	**I.**	**J.**		**L.**	**M.**	**N.**	**O.**		
12.	**A. RECIPIENT NAME** *(LAST, FIRST INITIAL)*	**B. Dates of Service (beginning) to (ending)**		**C. Recipient ID #** *(12 digits)*	**D. Transaction Control Number** *(17 digits)*							**E. Medical Rec. #**
	F. PRINCIPAL DIAGNOSIS CODE	**OTHER DIAGNOSES CODES**				**K. PRINCIPAL PROCEDURE CODE**	**OTHER PROCEDURE CODES**					**P. Amt. Refunded for Rec.**
		G.	**H.**	**I.**	**J.**		**L.**	**M.**	**N.**	**O.**		
13.	**A. RECIPIENT NAME** *(LAST, FIRST INITIAL)*	**B. Dates of Service (beginning) to (ending)**		**C. Recipient ID #** *(12 digits)*	**D. Transaction Control Number** *(17 digits)*							**E. Medical Rec. #**
	F. PRINCIPAL DIAGNOSIS CODE	**OTHER DIAGNOSES CODES**				**K. PRINCIPAL PROCEDURE CODE**	**OTHER PROCEDURE CODES**					**P. Amt. Refunded for Rec.**
		G.	**H.**	**I.**	**J.**		**L.**	**M.**	**N.**	**O.**		

Include attachments and corrected bills

	Ref. Numbers		Ref. Numbers
☐ Outpatient Admitted to Hospital . . .		☐ Codes were not keyed Correctly	
☐ Duplicate Payment		☐ Changed Codes	
☐ Third Party Payment		☐ Deductible Not Due	
☐ Spenddown/Self pay		☐ Blood Replacement	
☐ Paid as a Per Diem		☐ Lab Serv. Not Performed	
☐ Wrong pay rate		☐ Medicare Payment	

15. **REMARKS:**

SIGNATURE OF PROVIDER REPRESENTATIVE	Telephone Number	Date

ODJFS USE ONLY	**TCN#**	**to**	**TYPE**	**ACCT CODE**	**MMIS CODE**	**RSN**	**DATE UPDATED**	**INITIALS**

ODM 06766
Formerly JFS 06766 (Rev. 10/2013)

ADJ. REQUEST/CORRESPONDENCE (with supporting documentation, original, and one copy of form) to: Ohio Department of Medicaid, Claims Adjustment Unit, P.O. Box 309 Columbus, Ohio 43216-0309 (telephone 614-466-5080) Instructions to return overpayments can be found on the following Medicaid Web Link: Provider e-manuals---http://Medicaid.Ohio.gov/providers.aspx.

INSTRUCTIONS FOR COMPLETING THE ADJUSTMENT FORM ODM 06766

*REMITTANCE ADVICE MUST BE ATTACHED

1. **Provider Name:** Enter the name of the provider who actually received the Medicaid payment.

   Provider Address - Enter the complete mailing address; including city, state and zip code, of the provider who received the Medicaid Payment.

   Provider Number - Enter the seven (7) digit Ohio Medicaid Provider number assigned to the individual provider who received the Medicaid payment.

   National Provider Identification Number (NPI) (10 digits): Enter the 10-digit national provider identification number assigned to the facility.

2. **Check One -** All Adjustment requests on each JFS 06766 must be an initial request, follow-up request, final interim bill or exceptional cost outlier.

   An Initial Request - Check "initial request" if a JFS 06766 has not previously been submitted for the payment(s) in question.

   A Follow-Up Request - If a request has been previously submitted check the "follow-up request" block in red on a photostatic copy of the original JFS 06766. Do not complete a second JFS 06766.

   Find Interim Bill - Check this block if previous bills have been submitted for this patient at sixty (60) day intervals. (Codes 112, 122, 113, or 123 will have been checked in block 4 of the UB-82 forms submitted) The final interim bill must be submitted with code 111 in block 4. DRG exempt hospitals are to use code 114 and submit the final Interim bill through normal claims processing channels.

   Exceptional Cost Outlier - Check this block if the claim is to be paid as an exceptional cost outlier.

3. **Adjust Request/Correspondence (with supporting documentation, original, and one copy) -** Ohio Department of Medicaid, Adjustment Unit, P.O. Box 309, Columbus, Ohio 43216-0309.

4. **Bill Type:** Indicate the type of bill originally submitted (example - i.e., 111, 121). **If adjustments are to be requested for more than one type of bill, separate request forms must be submitted**.

5. **Admission Source -** Enter the appropriate one-digit code for source of admission. **If adjustments are to be requested for claims that have different source codes, separate request forms must be submitted.**

6. **Total Number of Claims:** Enter the total number of claims included in the request. If the total is more than six (6) claims, additional request forms must be submitted with the total number of claims involved entered on each form. Example: A request for 18 claims adjustments would require three (3) forms and the number 18 would be entered in this block on each form.

7. **Check One:** Check the appropriate block to indicate whether the request involves Medicare Crossover or Medicaid Claims. Do not include both types on the same submission. **If Medicare Crossover claims are submitted, the Explanation of Medicare Benefits (EOMB) must be attached.**

8. 8 -13 "A" through "P" (Recipient Information)

   A. Recipient Name - Enter the name of the recipient who actually received the service. Enter last name first.

   B. Dates of Service - Enter the six (6) digit dates of service (MMDDYY) in chronological order (first to last). Enter all six characters consecutively without dashes, slashes or spaces: Example: 010788 = January 7, 1988.

   C. Recipient ID# - Enter the ten (10) digit case number followed by the two (2) digit recipient number as printed on the Ohio Medicaid card. Enter this number without dashes, slashes or spaces.

   D. Transaction Control Number - Enter the seventeen (17) digit transaction control number (TCN) in question as it appears on the Medicaid remittance advice. Enter this number without dashes, slashes or spaces.

   E. Medical Record # - Enter the number assigned to the patient by the servicing hospital.

   F. Principal Diagnosis Code – Enter the three, four or five digit corrected ICD-9CM code for the principal diagnosis.

   G-J. Other Diagnosis Lades - Enter the three, four or five digit corrected ICD-9CM code identifying the principal surgical, obstetrical or medical procedure.

   K. Principal Procedure Code - Enter the three or four digit corrected ICD-9CM coda identifying the principal surgical, obstetrical or medical procedure.

   L-O. Other Procedure Codes - Enter the three or four ICD-9CM codes for other procedures.

   P. Amount Refunded for Recipient - Complete if either a separate refund check is enclosed for each service or if a refund for more than one service is included in a single check. Enter the amount which is being refunded for the specific recipient and service in this block (Please see item 3 above).

   14. Check the appropriate block(s) to Indicate the source(s) of the error(s) made for each recipient. Under the Reference Number Column enter the appropriate number(s) (8-13) opposite the error source(s).

   Example: If "Outpatient Admitted to Hospital" applies to the patients listed in lines # 6, 9 and 11, check that block and enter "8911" under "Reference Numbers". Enter these numbers without dashes, slashes or spaces.

Outpatient Admitted to Hospital	Check if an outpatient has been admitted to the hospital.
Duplicate Payment	Check if two (2) or more Medicaid payments have been paid to the provider from ODJFS for the same recipient, dates of service and type of service. No bill would be required, only attachment(s).
Third Party Payment	Check when provider has received payment from a private insurance company or other source(s), and Medicaid has paid. Enter the amount received from the third party source in the remarks section.
Spenddown/Selfpay	Check when a provider has received payment from a recipient.
Paid as per diem	Check when claim was paid either as a transfer or as partial eligibility, and should have been paid at the full DRG rate (corrected bill must reflect change in codes, if any).
Wrong Pay Rate	For inpatient claims, check if the hospital believes the wrong DRG pay rate was used in calculating payment. For outpatient claims, check if the hospital believes the wrong hospital rate or lab tee payment schedule was used in calculating payment.
Codes Were Not Keyed Correctly	Check when the hospital believes the department applied the wrong code; irrespective of the code indicated on the original bill. Include a copy of the original bill for documentation.
Hospital Changed Codes, Diagnosis, Procedure, or Condition Code(s)	Check when the hospital has altered, deleted or added a code. Enclose a copy of the corrected bill. Also use this block for change in source or discharge codes; with corresponding explanation under remarks.
Deductible Not Due Blood	Check if the Medicare deductible was not due for the date of service.
Replacement	Check this block to receive reimbursement for blood replacement. Enter the number of units and the dollar amount in the remarks section.
Lab Services Not Performed	Check if lab services were not performed for the dates of services indicated on bill.
Medicare Payment	Check if the recipient is eligible for Medicare for the dates of service.