

ValueOptions

Colorado Medicaid Adjustment Form

Adjustment **Reversal** **Payment Increase** **Payment Decrease**

Provider Name:	Member Name:
Provider Number:	Member ID Number:
Provider Address:	Claim Number:
	Paid Date:

Reason for Adjustment

- Member Name/Member ID #:
Correct Member: _____ Correct ID # : _____

- Date of Service:
Incorrect Date: _____ Correct Date: _____

- Billing Code Error:
Incorrect Code: _____ Correct Code: _____

- Units Incorrect:
Incorrect Units: _____ Correct Units: _____

- Provider / Vendor Paid:
Incorrect Provider #: _____ Correct Provider #: _____
Incorrect Vendor #: _____ Correct Vendor #: _____

- Other Reimbursement Received:
Source: _____ Amount: _____

- Authorization Extended:
Authorization Number: _____

- Other: (Please Explain)

Provider Signature: _____ Date: _____

ValueOptions Use Only

Processor: _____ **Code:** _____ **Date Completed:** _____