# Adjustment Request

**Return Requests to:**
**Iowa Medicaid Enterprise**
**PO Box 36450**
**Des Moines, IA 50315**

**Download this form @** http://www.ime.state.ia.us/Providers/Forms.html#DF

## SECTION A: Reason for adjustment; please select at least one reason.

- **A corrected claim and/or remittance advice (with changes, when applicable) must be attached with each request.**
- **Denied claims should be resubmitted**
- **Do not use red ink**

Please select changes or corrections to be made:

☐ Primary Insurance ☐ Dates of Service ☐ Medical Review Needed

☐ Patient Liability ☐ Diagnosis Code(s)

☐ Medicare Adjustment (EOMB from Medicare must be attached)

☐ Units Line Number(s) _____

☐ Billed Amount Line Number(s) _____

☐ Procedure Code(s) Line Number(s) _____

☐ Modifier(s) Line Number(s) _____

☐ Adding New Claim Detail Line Number(s) _____

Please Specify the Reason for the Adjustment Request:

## SECTION B: This section must be completed to process the request.

- 17-Digit TCN: _____
- NPI Number: _____ Taxonomy: _____ Zip: _____
- State ID: _____ Patient Acct #: _____

Signature: Date: