South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

- Void
- Void/Replace

Originator:

- DHHS
- MCCS
- Provider
- MIVS

Reason For Adjustment: (Fill One Only)

- Insurance payment different than original claim
- Keying errors
- Incorrect recipient billed
- Voluntary provider refund due to health insurance
- Voluntary provider refund due to casualty
- Voluntary provider refund due to Medicare
- Medicaid paid twice - void only
- Incorrect provider paid
- Incorrect dates of service paid
- Provider filing error
- Medicare adjusted the claim
- Other

For Agency Use Only

Analyst ID:

- Hospital/Office Visit included in Surgical Package
- Independent lab should be paid for service
- Assistant surgeon paid as primary surgeon
- Multiple surgery claims submitted for the same DOS
- MMIS claims processing error
- Rate change
- Web Tool error
- Reference File error
- MCCS processing error
- Claim review by Appeals

Comments:

Signature: _____ Date: _____

Phone: _____

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