Wyoming Department of Health

Adjustment/Void Request Form

PART A – Request Type

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☐ **1a CLAIM ADJUSTMENT**

Attach a copy of the claim with corrections made in **BLUE INK**.

DO NOT USE HIGHLIGHTER

Complete both Section B and Section C.

If attaching a check, make check payable to Division of Healthcare Financing (DHCF).

☐ **1b VOID CLAIM**

Attach a copy of the claim or Remittance Advice.

Complete both Section B and Section C.

If attaching a check, make check payable to Division of Healthcare Financing (DHCF).

☐ **2 CANCELLATION OF THE ENTIRE REMITTANCE ADVICE**

Every claim on the Remittance Advice must be incorrect. This option should only be used in rare instances.

Complete Section C only.

Attach Remittance Advice.

If manual check, attach the check from DHCF.
If EFT, make payable to DHCF for the entire remit amount.

PART B – Claim Information

If you selected either 1a or 1b, complete all of the following fields to facilitate processing. If you selected 2, skip this section.

Transaction Control Number (TCN) _____ **Payment Date** _____

Provider Name _____ **NPI/Provider Number** _____

Member ID _____ **Prior Authorization Number** _____

Date of Service	Proc Code/ Revenue Code	Charges	Service Line of Claim	Units	Other

Reasons for Adjustment or Void *(Check one or more.)*

☐ Billed in error ☐ Billed incorrect units ☐ Billed incorrect procedure code(s)

☐ Billed incorrect amount ☐ Receipt of TPL or Medicare Payment ☐ Other: _____

PART C – Signature and Date

Provider Signature _____ **Date** _____

INTERNAL USE ONLY BELOW THIS LINE

Adjusted By _____ **Date** _____

Mail completed form and attachments to:
Wyoming Medicaid Fiscal Agent
Attn: Claims Department
P.O. Box 547
Cheyenne, WY 82003-0547

WYBMS-Adjustment/ Void form