PROVIDER'S REQUEST FOR ADJUSTMENT

Dept of Labor & Industries
Crime Victims Compensation
PO Box 44520
Olympia WA 98504-4520

Please type or print in dark ink

DO NOT WRITE IN SPACE >

CHECK ONE →
- ☐ Total overpayment
- ☐ Partial overpayment
- ☐ Underpayment

ENTER DATA FROM ORIGINAL REMITTANCE ADVICE

INSTRUCTIONS APPEAR ON REVERSE SIDE

1) Claimant's name Last First M. Initial

2) Claim number on remit advice

3) Correct claim number

4) Provider name and address

5) ICN number on remittance advice

6) Provider number

7) Payee number

COMPLETE ONLY THOSE LINE ITEMS PREVIOUSLY PAID/DENIED IN ERROR - ENTER ONLY CORRECTED INFORMATION

8) Line Item No	a) From/to Date of Service or Covered Dates	b) POS	c) TOS	d) Procedure Code/ Revenue Code/NDC	e) Code Mod	f) ICD-9-CM Diagnosis/ Side of body	g) Tooth No	h) Charge	i) Days/ Units/ Qty	j) Days supply	k) Description
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
11											
12											
13											
14											

9) Other remarks/justification/special circumstances - attach required reports - explain fully

CLAIM NUMBER

V-

Date

Phone number
( )

Signature

ADJUSTMENT REQUEST FORM

THE ADJUSTMENT REQUEST FORM MAY BE USED IN THE FOLLOWING INSTANCES:

TOTAL OVERPAYMENT ----- Entire bill was paid in error. You may either submit an Adjustment Request Form and we will process a credit to recover our payment; OR you may issue a refund check directly to the Department. If a refund is submitted, you must attach a copy of the remittance advice indicating the ICN overpaid. Submit refunds to:

Cashiers Office
Department of Labor and Industries
PO Box 44835
Olympia WA 98504-4835

PARTIAL OVERPAYMENT --- A portion of the bill was overpaid. Complete Adjustment Request Form with correct information, including date of service, for the procedures/items paid incorrectly.

UNDERPAYMENT ---------- If a bill has been underpaid in error, the Adjustment Request Form must be completed with all pertinent information including date of service. Corrections or justification and/or reports must be included.

This form may **NOT** be used for:

Bills returned to you by the Department.
Totally denied bill. New bill must be submitted.

INSTRUCTIONS FOR COMPLETING ADJUSTMENT REQUEST

Submit only one form for each ICN (Internal Control Number).
Attach a copy of remittance advice and original bill.

1. **CLAIMANT'S NAME:** Clearly print claimant's full name.
2. **CLAIM NUMBER ON REMITTANCE ADVICE:** Enter the 7-digit number found in the Claim Number column on the remittance advice.
3. **CORRECT CLAIM NUMBER:** Claim number these services should be paid under.
4. **PROVIDER NAME AND ADDRESS:** Enter the name and address of the provider providing the service. Include telephone number.
5. **ICN NUMBER:** Enter the 17-digit number found in the ICN column to identify the bill submitted.
6. **PROVIDER NUMBER:** Enter the Crime Victims provider account number for the provider of service as it appears on the remittance advice.
7. **PAYEE NUMBER:** Enter the Crime Victims payee account number if payee was **different** than the provider of service.
8. **SERVICE ITEMIZATION:** Complete only for those line items to be corrected. Enter corrected information on line item number corresponding to line item number on original bill.
   a. **From/to Date of Service or Covered Dates:** Date of service, from and to date if date span previously billed. Admit and discharge date for hospital bill.
   b. **Place of Service:** (POS) Two digit code identifying the place service was performed.
   c. **Type of Service:** (TOS) One digit code identifying the general type of service performed.
   d. **Procedure Code/Revenue Code/NDC:** Identify correct procedure, hospital service or national drug code.
   e. **Code Mod:** Modifier used to identify special circumstances for a service or procedure.
   f. **ICD-9-CM and DSM III or IV Diagnosis/Side of Body:** Enter appropriate diagnosis code for condition treated. Designate left or right side of body where applicable.
   g. **Tooth Number:** For dental services only. Enter the two digit identification number of the specific tooth number treated (e.g., 08).
   h. **Charge:** Total of charges for services provided this line.
   i. **Days/Units/Quantity:** Total days stay for hospital accommodation codes, unit of service for procedure (time units, hours, miles, etc.), number of items (tablets, milliliters, etc.).
   j. **Days Supply:** Total number of days a prescription is intended to cover.
   k. **Description:** Describe procedure or service.
9. **OTHER REMARKS / JUSTIFICATION / SPECIAL CIRCUMSTANCES:** Enter sufficient justification for adjustment. Indicate the service line and date of service. Attach required reports.