State of Oregon D	f Oregon Department of Human Services								Division of Medical Assistance Programs													
Individual Adjustment Request									DMAP Use Only													
" Complete this form to request an adjustment.																						
Please keep a copy and do not use red ink.																						
Type of Adjustment: □ Underpayment – Request ad     □ Overpayment – Please deduction																						
2) Attach the following:  " Claim (corrected copy)  " Remittance Advice (copy)  " Financial planner (NH only)					(3) Return <u>nurs</u> adjustment   DMAP – I PO Box 1 Salem, C					requests to: requ NH DN 4954 PC					rn <u>all other</u> adjustment ests to: IAP Box 14952 Iem, OR 97309							
Enter the following data from your Remittance Advice (RA):																						
4 Internal Control Numb	nal Control Number												(5	R	A D	ate	!					
6 Recipient Name		7 Re					cipient ID Number															
8 Provider Name								Provider Number														
10 NPI						(	(11) <b>T</b>	axon	on	ny C	ode											
12) Description of original error				13	13 Line No. 14 Se										(1	16 Right Information						
□ Place of Service																						
□ Procedure Code/NDC/Rev Code																						
□ Modifier																						
□ Quantity/Unit																						
□ Diagnosis																						
□ Prescribing/Performing Provider																						
☐ Billed Amount/Total Billed																						
□ Medicare Payment																						
□ Other Insurance/Patient Liability																						
□ Co-Insurance																						
□ Other																						
17) Remarks																						
																					_	
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18) Provider's Signature							F	Phone	e #							D	Date					