

Dallas Area NorthSTAR Adjustment Form

Adjustment
 Reversal
 Payment Increase
 Payment Decrease

Provider Name:	Enrollee Name:
Provider MHS Number:	NorthSTAR ID Number:
Provider Address:	Claim Number:
	Paid Date:

Reason for Adjustment

- Enrollee Name/NorthSTAR ID #:

Correct Enrollee: _____ Correct ID #: _____
- Date of Service:

Incorrect Date: _____ Correct Date: _____
- Billing Code Error:

Incorrect Code: _____ Correct Code: _____
- Units Incorrect:

Incorrect Units: _____ Correct Units: _____
- Provider / Vendor Paid:

Incorrect Provider #: _____ Correct Provider #: _____

Incorrect Vendor #: _____ Correct Vendor #: _____
- Other Reimbursement Received:

Source: _____ Amount: _____
- Authorization Extended:

Authorization Number: _____
- Other: (Please Explain)

If there are any questions regarding this adjustment request, please contact *ValueOptions'* Customer Service Department at **1-888-800-6799**.

Provider Signature: _____ Date: _____

ValueOptions Use Only

Processor: _____ **Code:** _____ **Date Completed:** _____