

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME _____
 PROVIDER PROVIDER NUMBER _____

CONTACT PERSON _____
 TELEPHONE NUMBER _____

QUARTER ENDING: (Circle One) 3/31 6/30 9/30 12/31 YEAR _____

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	
	RECIPIENT FIRST NAME	RECIPIENT LAST NAME	MEDICAID NUMBER	FROM DATE OF SERVICE	TO DATE OF SERVICE	TOTAL BILLED CHARGES	PAID DATE	PAID AMOUNT	PROVIDER'S PATIENT ACCOUNT #	MEDICAID TCN	AMOUNT OF CREDIT BALANCE	AMOUNT OF OVERPAYMENT	PATIENT LIABILITY	CO-INSURANCE	CO-PAYMENT	DEDUCTIBLE	REASON FOR CREDIT BALANCE (SEE BELOW)*	COB PLAN NAME	COB POLICY NUMBER	COB PAID AMOUNT	COB PAID DATE	COB ICN #	Replacement ICN	Recovery Code (See Below)*	Claim Type(See Below)*	Comment Type(See Below)*	
1.																											
2.																											
3.																											
4.																											
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10.																											
11.																											
12.																											
13.																											
14.																											
15.																											

Circle One: Refund Adjustment

Credit Balance Refund Reasons:

- (1) Adjusted Bill Amount (3) Duplicate Payment
- (2) Commercial/Other (4) Other

If the Refund Reason is (2) Commercial/Other Payment the COB Information is required and the sheet will not process if data is missing.

Recovery Codes:

- (1) HMS to Adjust (5) Provider to Adjust
- (2) HMS to Void (6) Provider to Void
- (3) Provider Adjusted (7) Provider Voided
- (4) Provider Check (8) Web Void

Claim Type Codes:

- (1) Outpatient Hospital (4) Medicare Crossover Institutional
- (2) Outpatient Clinic (5) Medicare Crossover Professional
- (3) Inpatient Hospital (6) Physician

Comments Types:

- (1) Per provider's Amnesty report; other insurance is primary.
- (2) Per provider's Amnesty report; Medicare amended claim no secondary responsibility.
- (3) Per provider's Amnesty report; duplicate payment made by Medicaid.
- (4) Per provider's Amnesty report; claim results in an overpayment made on the behalf of Medicaid.

Contact Person: PSA NAME

Audit Type: Will be completed by HMS

NC Medicaid Credit Balance
 2508 Mail Service Center
 Raleigh, NC 27699-2508

Office of the Controller
 2022 Mail Service Center
 Raleigh, NC 27699-2022

*Address to be used when sending LIVE checks with report(s).