

Ohio Department of Job and Family Services
ADJUSTMENT REQUEST FORM JFS 06767

*REMITTANCE ADVICE MUST BE ATTACHED

1. PROVIDER NAME <hr/> PROVIDER ADDRESS <hr/> <i>(CITY, ZIP CODE)</i> <hr/> PAY TO GROUP PROVIDER NUMBER (7 DIGITS) <hr/> NATIONAL PROVIDERS IDENTIFIER (10 DIGITS) <hr/>	2. CHECK ONE <input type="checkbox"/> an initial request <input type="checkbox"/> a follow-up request	3. ONE CHECK ENCLOSED CHECK NO. _____ CHECK AMT. _____ <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> OTHER	4. CLAIM TYPE <input type="checkbox"/> CLINIC <input type="checkbox"/> INDEPENDENT LAB <input type="checkbox"/> HOME HEALTH <input type="checkbox"/> PHYSICIANS <input type="checkbox"/> EPSDT <input type="checkbox"/> MEDICAL SUPPLIES <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> AMBULANCE <input type="checkbox"/> OTHER _____
5. TOTAL NUMBER OF CLAIMS _____		6. CHECK ONE <input type="checkbox"/> Medicare Crossover <input type="checkbox"/> Medicaid	

RECIPIENT INFORMATION

7. A. RECIPIENT NAME (LAST, FIRST, INITIAL)	B. DATE OF SERVICES (beginning) _____ to (ending) _____	C. RECIPIENT ID#	D. Transaction Control Number	E. Prior Authorization
F. Incorrect Code/Units/Modifier	G. Correct Code/Units/Modifier	H. Reason for Refund <input type="checkbox"/> Private Insurance <input type="checkbox"/> Other		M. ATTACHMENTS <input type="checkbox"/>
I. Check Number	J. Check Amount	K. Amt. Refunded for Rec.	L. Medicaid Paid	
8. A. RECIPIENT NAME (LAST, FIRST, INITIAL)	B. DATE OF SERVICES (beginning) _____ to (ending) _____	C. RECIPIENT ID#	D. Transaction Control Number	E. Prior Authorization
F. Incorrect Code/Units/Modifier	G. Correct Code/Units/Modifier	H. Reason for Refund <input type="checkbox"/> Private Insurance <input type="checkbox"/> Other		M. ATTACHMENTS <input type="checkbox"/>
I. Check Number	J. Check Amount	K. Amt. Refunded for Rec.	L. Medicaid Paid	
9. A. RECIPIENT NAME (LAST, FIRST, INITIAL)	B. DATE OF SERVICES (beginning) _____ to (ending) _____	C. RECIPIENT ID#	D. Transaction Control Number	E. Prior Authorization
F. Incorrect Code/Units/Modifier	G. Correct Code/Units/Modifier	H. Reason for Refund <input type="checkbox"/> Private Insurance <input type="checkbox"/> Other		M. ATTACHMENTS <input type="checkbox"/>
I. Check Number	J. Check Amount	K. Amt. Refunded for Rec.	L. Medicaid Paid	
10. A. RECIPIENT NAME (LAST, FIRST, INITIAL)	B. DATE OF SERVICES (beginning) _____ to (ending) _____	C. RECIPIENT ID#	D. Transaction Control Number	E. Prior Authorization
F. Incorrect Code/Units/Modifier	G. Correct Code/Units/Modifier	H. Reason for Refund <input type="checkbox"/> Private Insurance <input type="checkbox"/> Other		M. ATTACHMENTS <input type="checkbox"/>
I. Check Number	J. Check Amount	K. Amt. Refunded for Rec.	L. Medicaid Paid	
11. A. RECIPIENT NAME (LAST, FIRST, INITIAL)	B. DATE OF SERVICES (beginning) _____ to (ending) _____	C. RECIPIENT ID#	D. Transaction Control Number	E. Prior Authorization
F. Incorrect Code/Units/Modifier	G. Correct Code/Units/Modifier	H. Reason for Refund <input type="checkbox"/> Private Insurance <input type="checkbox"/> Other		M. ATTACHMENTS <input type="checkbox"/>
I. Check Number	J. Check Amount	K. Amt. Refunded for Rec.	L. Medicaid Paid	
12. A. RECIPIENT NAME (LAST, FIRST, INITIAL)	B. DATE OF SERVICES (beginning) _____ to (ending) _____	C. RECIPIENT ID#	D. Transaction Control Number	E. Prior Authorization
F. Incorrect Code/Units/Modifier	G. Correct Code/Units/Modifier	H. Reason for Refund <input type="checkbox"/> Private Insurance <input type="checkbox"/> Other		M. ATTACHMENTS <input type="checkbox"/>
I. Check Number	J. Check Amount	K. Amt. Refunded for Rec.	L. Medicaid Paid	

DEPARTMENTAL USE ONLY	
Trans. # _____	
Type _____	ACCT. CODE _____
MMIS CODE _____	RSN _____
DATE UPDATED _____	INITIALS _____

13. REMARKS:

SIGNATURE OF PROVIDER REPRESENTATIVE _____	TELEPHONE NUMBER _____	DATE _____
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INSTRUCTIONS FOR COMPLETING THE ADJUSTMENT REQUEST FROM JFS 06767

1. **Provider Name:** Enter the name of the provider who actually received the Medicaid payment.

Provider Address - Enter the complete mailing address; including city, state and zip code, of the provider who received the Medicaid payment.

Provider Number - Enter the seven (7) digit Medicaid Provider number assigned to the individual provider who received the Medicaid payment. This must be completed for an adjustment to occur.

National Provider Identifier Number – Enter the ten (10)-digit NPI number. The NPI and Provider number will ensure appropriate processing of claims.

2. **Check One** - All adjustment requests on each JFS 06767 must be either an initial request or follow-up request:

An Initial Request - Check "initial request" if a JFS 06767 has not previously been submitted for the payment(s) in question.

A Follow-Up Request - If a request has been previously submitted check the "follow-up request" block in **red** on a photostatic copy of the original JFS 06767. Do not complete a second JFS 06767.

3. **One Check Enclosed** - Complete this block when reimbursing ODJFS if only one check is submitted. One check may be used to cover more than one adjustment, provided all the adjustments are included in the same submission. If the check, covers more than one service with different reasons for refunds, check neither block; instead complete the "reason for refund" blocks as explained under item 7 "H" below. If more than one check is enclosed, do not use this block; instead enter the check numbers and amounts in the "Recipients information" section explained under 7 item "I" and "J" below.

Check No. - Enter the number of the check enclosed.

Check Amount - Enter the total dollar amount of the check enclosed.

Private Insurance - Check the "private insurance" block if the refund resulted from a third-party payment.

Other - Check the "other" block if the refund is from sources other than private insurance and provide a brief explanation in the remarks section.

4. **Claim Type:** Check the type of claim(s) originally submitted. If adjustments are to be requested for more than one type of claim. separate request forms must be submitted.
5. **Total Number of Claims:** Enter the total number of claims included in the request. If the total is more than six (6) claims, additional request forms must be submitted with the total number of claims involved entered on each form. Example: A request for 18 claims adjustments would require three (3) forms and the number 18 would be entered in this block of each form.
6. **Check One:** Check the appropriate block to indicate whether the request involves either Medicare Crossover or Medicaid Claims. Do not include both types on the same submission.

7. **7 - 12 "A" through "M":** (Recipient Information)

A. Recipient Name - Enter the name of the recipient who actually received the service. Enter last name first.

B. Dates of Service - Enter the six (6) digit dates of service (MM/DD/YY) in chronological order (first to last). Enter all six characters consecutively with slashes; example: 010788 = 01/07/88.

C. Recipient IDM - Enter the ten (10) digit case number followed by the two (2) digit recipient number as printed on the Medicaid card. The recipient number can be found in the block marked "ADC number" on the Ohio Medicaid card.

D. Transaction Control Number - Enter the transaction control number (TCN) in question as it appears on the remittance advice.

E. Prior Authorization - Complete only if Prior Authorization was required for the services billed. Enter the six (6) digit number from the Prior Authorization form (JFS 03142 or JFS 03612) which authorized the procedure.

F. Incorrect Code/Unit(s)/Modifier - Enter the **incorrect code**, unit(s), or modifier as they appear on the Remittance Advice. If the code, unit(s), or modifier is correct, leave this and the following space blank.

G. Correct Code/Unit(s)/Modifier - If the original code, unit(s) or modifier of service was incorrect, enter the correct code, unit(s) or modifier.

H. Reason for Refund - Complete this item if more than one check is enclosed with the request. Check either the "Private Insurance" or "Other" block; depending on the source of Third Party payment (Please see Item 3 above for exceptions).

I. Check Number - If more than one check is enclosed, enter the number of the check applicable to the specific recipient.

J. Check Amount - If more than one check is enclosed, enter the total amount applicable to the specific recipient.

K. Amount Refunded for Recipient - Complete if a single check is enclosed. Enter the portion of the check amount which is being refunded for the specific recipient and service. (Please see Item 3 above for exceptions).

L. Medicaid Paid - Enter the amount paid by Medicaid for the specific recipient, as it appears on the Remittance Advice.

M. Attachments - Check this block if document(s) relating to the request are included in the information sent. (Example: Prior Authorization forms, a Remittance Advice with a different pay date showing duplication).

Remarks: Complete this section to explain "other" reason for refund (H) using items 7 - 12 for reference. if appropriate, or when requesting additional payment. Further clarification of the error to be corrected may also be included in this section. The name and work phone of the person who should be contacted with regards to the payment in question should be included, if different from the person completing the form.

Signature, Telephone Number, Date - Enter the signature of the Provider representative responsible for completing the form, the telephone number (including area code) where they may be reached, and the date the form was completed.