INDIANA OFFICE OF MEDICAID POLICY AND PLANNING - CREDIT BALANCE WORKSHEET

1. PROVIDER NAME: _____ **4. DATE:** _____

2. MEDICAID PROVIDER #: _____ **5. CONTACT PERSON:** _____

3. TELEPHONE NUMBER: _____ **6. THIRD PARTY TYPE:** HEALTH___ MEDICARE___ CASUALTY___ OTHER___

7. PATIENT NAME	8. MEDICAID ID NUMBER	9. MEDICARE ID NUMBER	10. EMPLOYER NAME
11. INSURER NAME	**12. POLICY HOLDER NAME**	**13. POLICY NUMBER**	**14. GROUP NUMBER**

HMS PROJECT (OFFICE USE ONLY)
General

15. PAY TO PROVIDER NUMBER	16. CLAIM CONTROL NUMBER	17. SERVICE DATES BEGIN	END	18. MEDICAID PAID AMOUNT	19. REFUND AMOUNT
				22. TOTAL THIS PAGE	

20. TOTAL REFUND AMOUNT FROM ALL PAGES	21. CLAIM LEVEL ADJUSTMENT TO OCCUR IMMEDIATELY?
	YES / NO

Please direct questions to (877) 264-4854. **Please fax completed worksheets to (214) 905-2064.**