INDIANA HEALTH COVERAGE PROGRAMS (IHCP)

CREDIT BALANCE WORKSHEET INSTRUCTIONS

1. **PROVIDER NAME** – This field must contain the name of the provider that received payment from IHCP.
2. **MEDICAID PROVIDER #** – This field must contain the nine (9) digit provider number assigned by IHCP.
3. **TELEPHONE NUMBER** – This field must contain the telephone number of the contact person.
4. **DATE** – This field must contain the current date.
5. **CONTACT PERSON** – This field must contain the name of the person in your organization familiar with the listed credit balances.
6. **THIRD PARTY TYPE** – This field must be checked to determine what other payor type was involved in the credit balance, if any.
7. **PATIENT NAME** – This field must contain the name of the patient.
8. **MEDICAID ID NUMBER** – This field must contain the twelve (12)-digit Recipient Identification number (RID), assigned to the recipient.
9. **MEDICARE ID NUMBER** – This field must contain the Health Insurance Claim number assigned by Medicare.
10. **EMPLOYER NAME** – This field must contain the name of the employer.
11. **INSURER NAME** – This field must contain the name of the third party insurer, if any.
12. **POLICY HOLDER NAME** – This field must contain the name of the policy holder or employee.
13. **POLICY NUMBER** – This field must contain the policy number assigned by the third party insurer.
14. **GROUP NUMBER** – This field must contain the insurer's number for the employer's plan.
15. **PAY TO PROVIDER NUMBER** – This field must contain the nine (9)-digit provider number assigned by IHCP that the refund originates from. Be sure to include your service location.
16. **CLAIM CONTROL NUMBER** – This field must contain the thirteen (13) digit number assigned to the claim.
17. **SERVICE DATES** – This field must contain the service dates of the claim.
18. **MEDICAID PAID AMOUNT** – This field must contain the amount paid by IHCP.
19. **REFUND AMOUNT –** This field must contain the amount owed to IHCP as refund.
20. **TOTAL REFUND AMOUNT FROM ALL PAGES –** This field must include the total refund amount from all pages.
21. **CLAIM LEVEL ADJUSTMENT TO OCCUR IMMEDIATELY** – "YES" must be circled if an adjustment is to occur immediately. "NO" must be circled if an adjustment is not to occur immediately.
22. **TOTAL THIS PAGE** – This field must contain page number information. Example "1 of3".