DMAP 1036

Individual Adjustment Request (IAR)
billing instructions for the
Department of Human Services

DHS
Oregon Department
of Human Services

Overview

This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the DMAP 1036 individual adjustment request form correctly the first time. If applicable, this presentation is to be used in conjunction with General Rules, provider guidelines and supplemental information.

We hope you find this tutorial helpful.

~ DHS ~

About the DMAP 1036

- The DMAP 1036 individual adjustment request form is unique. It is designed to correct overpayments and underpayments for all providers that bill DMAP for services provided to Oregon Health Plan (OHP) clients.
- Use this form for:
  - Use of a wrong procedure code
  - Errors entering data
  - Errors in pricing
  - Payment received from other resources

A few tips!

- When a provider realizes that DMAP has overpaid or underpaid a claim, the provider should submit a completed DMAP 1036 form.
- Only adjudicated claims can be adjusted.
- Do not submit a new claim.
- Submit one adjustment form per claim.
- Denied claims must be re-billed.

Information needed

- When the original claim was adjudicated, a remittance advice (RA) statement was sent to the provider to document payment of the claim.
- The RA for the original claim provides most of the information needed to file an adjustment.
- Adjustment requests must show specifically what needs to be changed, with both incorrect and correct information.

What happens at DMAP

- When DMAP receives the completed DMAP 1036 form, staff review the form to ensure all information entered on the form is complete and accurate.
- A new Internal Control Number (ICN) is assigned to the request and entered into the computer system, which then checks and cross-references the original claim against the adjustment.
- DMAP staff then processes the request.

Adjustment results

- Once the adjustment request passes all reviews, DMAP then takes steps to reconcile the underpayment or overpayment.
- If the original claim was underpaid, DMAP’s next regular payment to the provider will include the adjustment.
- If the original claim was overpaid, DMAP’s next regular payment to the provider will deduct the amount of the overpayment from the total amount due to the provider.

Introducing the DMAP 1036

Print Form | Reset Form | "Save As" to desk top

State of Oregon | Department of Human Services | Division of Medical Assistance Programs

Individual Adjustment Request

✓ Complete this form to request an adjustment.

✓ Please keep a copy and do not use red ink.

DMAP Use Only

(1) **Type of Adjustment:** ☐ Underpayment – Request additional payment
☐ Overpayment – Please deduct from subsequent payment

(2) **Attach the following:**
- ✓ Claim (corrected copy)
- ✓ Remittance Advice (copy)
- ✓ Financial planner (NH only)

(3) **Return nursing home adjustment requests to:**
DMAP – NH
PO Box 14954
Salem, OR 97309

Return all other adjustment requests to:
DMAP
PO Box 14952
Salem, OR 97309

Enter the following data from your Remittance Advice (RA):

(4) **Internal Control Number** | (5) **RA Date**

(6) **Recipient Name** | (7) **Recipient ID Number**

(8) **Provider Name** | (9) **Provider Number**

(10) **NPI**

(11) Description of original error	(12) Line No.	(13) Service Date	(14) Wrong Information	(15) Right Information
☐ Place of Service				
☐ Procedure Code/NDC/Rev Code				
☐ Modifier				
☐ Quantity/Unit				
☐ Diagnosis				
☐ Prescribing/Performing Provider				
☐ Billed Amount/Total Billed				
☐ Medicare Payment				
☐ Other Insurance/Patient Liability				
☐ Co-Insurance				
☐ Other				

(16) **Remarks**

(17) Provider's Signature	Phone #	Date

Top section

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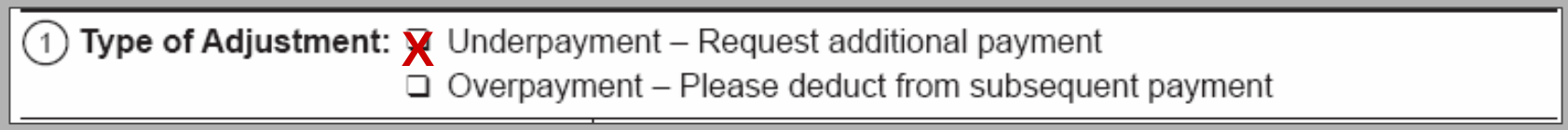
Red = Required

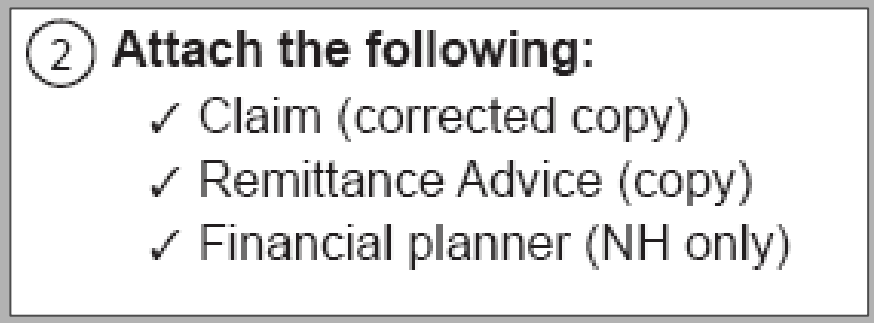
Box 1 - Required



Type of Adjustment

- Check the box that applies to the claim you are requesting an adjustment be made to.
- Check underpayment if DMAP paid too little.
- Check overpayment if DMAP paid too much.

Box 2 - Optional



Attachments

- You may attach additional information to help facilitate the processing of your request.

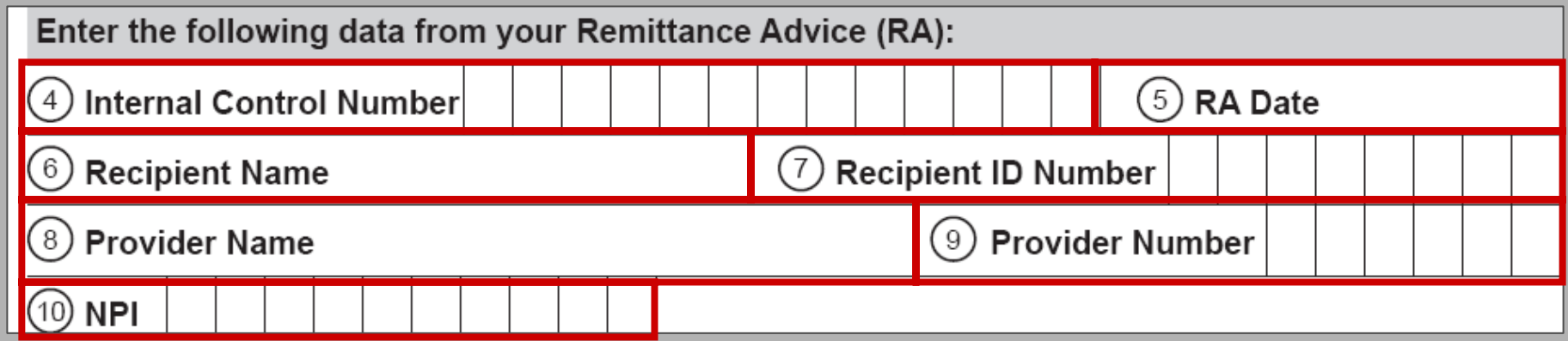
Box 3

(3) **Return <u>nursing home</u> adjustment requests to:** DMAP – NH PO Box 14954 Salem, OR 97309	**Return <u>all other</u> adjustment requests to:** DMAP PO Box 14952 Salem, OR 97309

Mailing address

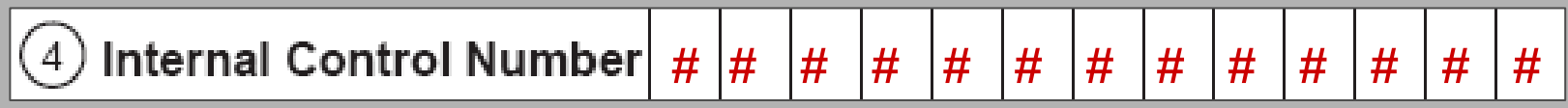
- Mail your completed DMAP 1036 form to the address listed in this box.

Middle section



Red = Required

Box 4 - Required



Internal Control Number

- List the thirteen-digit Internal Control Number (ICN) of the claim that you are applying an adjustment to.
- The ICN is located on your Remittance Advice (RA).

Box 5 - Required

Remittance Advice (RA) Date

- Enter the date printed on the RA.
- The date is located at the top of your RA.

Box 6 - Required

Recipient Name

- Enter the recipient name as it appears on the RA.
- Enter the last name first.

Box 7 - Required

7 Recipient ID Number	X	X	#	#	#	X	#	X

Recipient ID Number

- Enter the recipient's eight-digit alpha/numeric prime identification number that is located on the RA.

Box 8 - Required

Provider Name

- Enter the provider name.
- The name is located at the top of the RA.

Box 9 - Required

Provider Number

- Enter the six-digit DMAP provider number.
- The provider number is located at the top of the RA.

Box 10 - Required

National Provider Identifier (NPI)

- Enter the ten-digit NPI.

Bottom section

(11) Description of original error	(12) Line No.	(13) Service Date	(14) Wrong Information	(15) Right Information
☐ Place of Service				
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☐ Other Insurance/Patient Liability				
☐ Co-Insurance				
☐ Other				

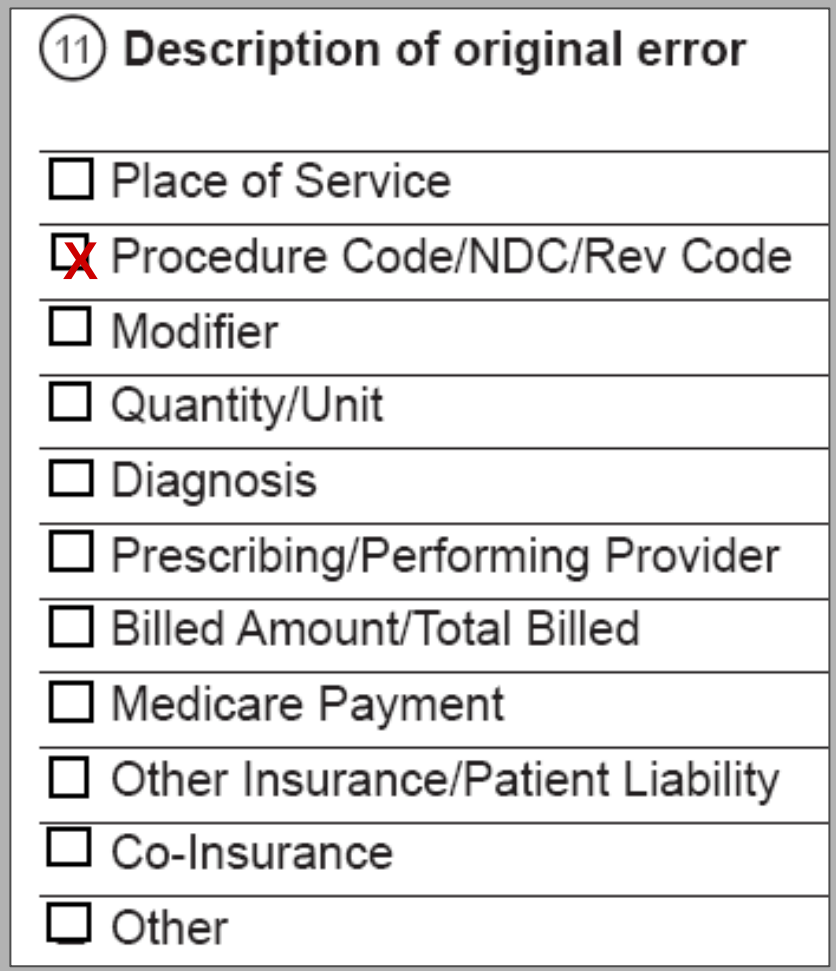
(16) **Remarks**

(17) Provider's Signature	Phone #	Date

Red = Required

Yellow = Optional

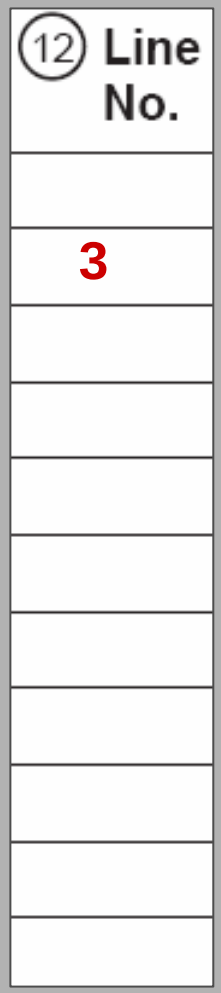
Box 11 - Required



Description of original error

- Only check the box or boxes that you want corrected on your claim form.

Box 12 - Required



Line number

- List the line number for the service you are requesting wrong or right information for.
- Count the line number from the claim as it appears on the RA.

Box 13 - Required

Service Date

- List the date of service for the service that was provided as indicated on the RA.

Box 14 - Required

Wrong Information

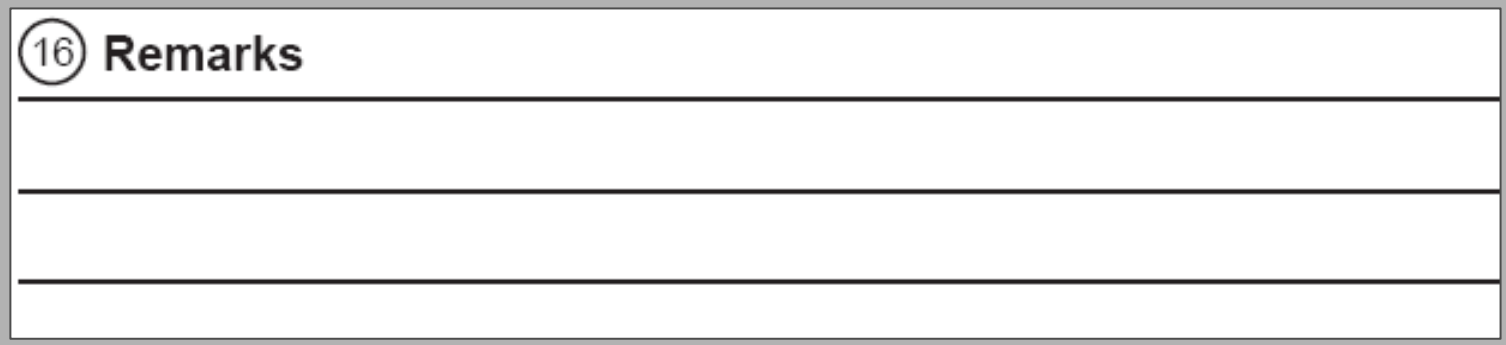
- List the incorrect (wrong) information submitted as it appears on the RA.

Box 15 - Required

Right Information

- List the correct (right) information that is necessary to process your request.

Box 16 - Optional



Remarks

- Use this box as needed.
- Provide us with any other information you think may be necessary to accurately adjust your request.

Box 17 - Required

(17) Provider's Signature	Phone #	Date
Dr. Clinic	503-###-####	## / ## / ##

Provider's Signature

- The provider or authorized representative must sign and date the request.
- It is suggested that you list your phone number. DMAP staff may need to contact you for questions pertaining to your request.

COMPLETED

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(4) **Internal Control Number** ########## (5) **RA Date** ##/##/##

(6) **Recipient Name** Patient, Your (7) **Recipient ID Number** XX#####X#X

(8) **Provider Name** Dr. Clinic (9) **Provider Number** ######

(10) **NPI** ##########

(11) Description of original error	(12) Line No.	(13) Service Date	(14) Wrong Information	(15) Right Information
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☐ Other				

(16) **Remarks**

(17) **Provider's Signature** *Dr. Clinic* **Phone #** 503-###-#### **Date** ##/##/##

EXAMPLE

Need Help?

- Contact DMAP Provider Services if you need assistance with your DMAP 1036 individual adjustment request form.

- They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: DMAP.providerservices@state.or.us

Thank You!