



Medicaid Credit Balance Report

15.0 Appendix J – Medicaid Credit Balance Report

Please see Appendix K for instructions on completing this form.

PLEASE PRINT

1. PROVIDER NAME: _____

2. PROVIDER NPI or DMAP Atypical #: _____

3. PROVIDER TAXONOMY: _____

4. REPORTING QUARTER: _____

5. CLIENT'S NAME: _____

6. MEDICAL ASSISTANCE ID#: _____

7. HOSPITAL ACCOUNT #: _____

8. DATE (S) OF SERVICE: _____

9. ICN#: _____

10. TOTAL CHARGES: _____

TOTAL PAID BY:

11. MEDICAID (DMAP): _____

12. MEDICARE: _____

13. OTHER INSURER(S)/PAYER(S): _____

14. CREDIT BALANCE: _____

15. REASON FOR CREDIT BALANCE: _____

16. NAME OF OTHER INSURER(S)/PAYER(S) AND PHONE NUMBERS: _____

SUBSCRIBER NAME: _____

POLICY NUMBER(S): _____

17. DATE CREDIT ESTABLISHED: _____

18. Payment by check _____

Remittance Advice attached _____

Managed care claim _____