MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

MassHealth Duplicate Remittance Advice Request Form Instructions

Dear Provider,

Thank you for contacting MassHealth Customer Service to request a duplicate remittance advice (RA).

Duplicate RA Fees

Please note that there is a **fee of $10.00 per invoice** for all duplicate RA requests. This fee will cover the cost of labor and materials required to produce and mail:

- a duplicate RA run of any size in PDF format on a CD-Rom; or
- a paper RA run of up to 200 pages.

Paper RA runs/invoices that exceed 200 pages will require an additional fee of $3.00 per 200 pages.

How to Request a Duplicate RA

Complete the enclosed form and attach a check in the amount of $10.00 for each run requested. Make the check payable to Customer Service Correspondence. Staple the check to the completed form and mail to: MassHealth RA Correspondence, P.O. Box 45, Boston, MA 02112-0045. Group practices Please Note: If you bill under an individual provider number please use that number on the form, rather than the group practice number.

Processing Time Frames

CD-ROM requests and paper requests of less than 200 pages will be processed within five business days of receipt of the form and check. In the event that your paper request exceeds 200 pages, a MassHealth Customer Service Representative will call to inform you of the additional fee. MassHealth will complete the RA request within three to five business days of receiving the additional fee.

RA Mailing Address

Duplicate RAs will be sent to the check mailing address that MassHealth has on file. If the RA needs to be forwarded to a third party, it is the provider's responsibility to do so.

Electronic Submitters

Electronic claim submitters have access to the HIPAA-compliant 835 Remittance Advice and Supplemental Electronic Remittance Advice via the MassHealth Web site, and do not need to request or pay for duplicate RAs through MassHealth. If you are interested in learning more about submitting claims electronically, or if you have any additional questions or concerns, please go to mass.gov/masshealth, or contact the MassHealth Customer Service Center at 1-800-841-2900.

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Complete Contact Information

Name			Telephone number
Street address	City	State	Zip
Provider number	Note to group practices: If you bill under individual provider numbers, please indicate the individual provider number, not the group practice provider number.		

Choose Format

☐ **CD ROM** PDF format	☐ **Paper** (There is an additional fee for paper copies over 200 pages.)

List Invoices

Please indicate one of the following invoice types in the invoice type column.

- Inpatient hospital (1)
- Medicare crossover (2)
- Outpatient hospital (3)
- EPSDT assessment (4)
- Physician (5)
- Pharmacy (6)
- Transportation (7)
- HMO (8)
- Medical services (9)
- Long term care (10)
- Dental (11)
- Dental (ADA)

Invoice Type	Run Number

Calculate Fee

Total Invoices	Fee per Invoice	Total Fee
	X $10.00 =	

Mail Form (Do not fax.)

Make check payable to: **Customer Service Correspondence**

Attach check to form and mail to:

MassHealth RA Correspondence
P.O. Box 45
Boston, MA 02112-0045