

**CONNECTICUT MEDICAL ASSISTANCE PROGRAM
PAID CLAIM ADJUSTMENT REQUEST (PCAR)**

Please Return To:

EDS
Connecticut Medical Assistance Program
PO Box 2981
Hartford, CT 06104

1) NPI/Non-Medical Provider Identifier 	
2) Remittance Advice Date 	3) Remittance Advice Number
4) Client ID 	

5) Client Name (Last, First)

6) Internal Control Number
| | | | | | | | | | | | | |

7) Reason for Request
 RECOUP ENTIRE CLAIM RECOUP DETAIL NUMBER(S) _____
 ADJUST CLAIM: PLEASE EXPLAIN:

If recouping detail(s), please complete boxes 8-12 then skip to box 29.

**Please copy the information requested in boxes 8 through 12 from the REMITTANCE ADVICE.
For additional details please attach an additional page.**

8) Claim Detail #	9) Dates of Service	10) NDC/RCC/Procedure Code	11) Days/Qty/Units	12) Billed Amount

Please complete only the boxes in the next two sections that pertain to the changes necessary to adjust the claim. For additional details please attach an additional page.

13) Type of Bill	14) Dates of Service	15) Admit Date	16) Total Days	17) Other Insurance Amount	18) Spenddown	19) Patient Status

20) Claim Detail #	21) Dates of Service mm/dd/ccyy	22) FTC	23)NDC/RCC/ Procedure Code	24) Modifier(s)	25) Days/Qty/Units	26) Tooth #/ Surface Code	27) Billed Amount

28) For LTC Providers only, additional data for the requested change:

29) Provider Name

30) Street Address

31) City, State, Zip Code

32) Authorized Signature

33) Date
| |

INTERNAL USE ONLY
 34) Initiated By
EDS DSS