

# Provider Void Claim

## Member Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Medicaid ID # \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_

Phone \_\_\_\_\_ Age \_\_\_\_\_ Gender:  Male  Female

**Claim Number(s)** *(For voiding a paid item, the correct claim number as shown on the EOP [Explanation of Payment] is always required.)*

**Claim Service Line Number or Procedure Code(s) Requesting to Void** *(Optional)*

**Date of Service** *(Optional)*

**Date of EOP Listed Claim was Paid**

**Reason for Void Other** *(Explanation Provider Information)*

## Provider Information

Provider Name \_\_\_\_\_ Tax ID # \_\_\_\_\_

Patient Account Number *(Optional)* \_\_\_\_\_

Authorized Signature (I certify the statements apply to this bill and are made a part hereof.)

## Physician or Supplier's Information

Physician Name \_\_\_\_\_ Physician NPI \_\_\_\_\_

Physician Address \_\_\_\_\_

Physician Phone \_\_\_\_\_

**Please submit the completed form to:**

**Louisiana Healthcare Connections**

**P.O. Box 3000 Farmington, MO 63640-3800**

*Processed Void Claim Request may be viewed on the Provider's Remittance Advice.*