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.