LOUISIANA HEALTHCARE CONNECTIONS™

PROVIDER VOID CLAIM FORM

PATIENT INFORMATION

1. LAST NAME

2. FIRST NAME, MI

3. DATE OF BIRTH

4. MEDICAID ID NUMBER

5. CLAIM NUMBER(S) (FOR VOIDING A PAID ITEM, THE CORRECT CLAIM NUMBER AS SHOWN ON THE EOP [EXPLANATION OF PAYMENT] IS ALWAYS REQUIRED)

5. a) CLAIM SERVICE LINE NUMBER OR PROCEDURE CODE(S) REQUESTING TO VOID (OPTIONAL)

6. DATE OF SERVICE (OPTIONAL)

6. a) DATE OF EOP LISTED CLAIM WAS PAID

7. REASON FOR VOID

OTHER: EXPLANATION

PROVIDER INFORMATION

8. PROVIDER NAME

9. PROVIDER TIN (TAX IDENTIFICATION NUMBER)

10. YOUR PATIENT'S ACCOUNT NUMBER (OPTIONAL)

11. AUTHORIZED SIGNATURE (I CERTIFY THE STATEMENTS APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

PHYSICIAN OR SUPPLIER'S INFORMATION

12. NPI NUMBER

13. PHYSICIAN NAME

14. PHYSICIAN ADDRESS

15. PHYSICIAN PHONE NUMBER

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.