NEW HAMPSHIRE MEDICAID ADJUSTMENT/RECOUPMENT REQUEST

CONDUENT

Please return to:

Conduent
PO Box 2003
Concord, NH 03302-2003

☐ **Adjustment**
or
☐ **Recoupment**

PROVIDER NAME	NPI (10 digits)	PROVIDER NUMBER
	RA#	RA DATE

MEMBER NAME	MEMBER MID	TCN

.LINE	BEGIN DOS	END DOS	PROC CODE	MOD	TH	SERVICE UNITS		BILLED AMOUNT	AMOUNT PAID

Please copy the information requested in boxes 8 through 18 from the Remittance Advice (RA)

19. Reason for adjustment or recoupment

20. Adjustment Reason Code and Converted TCN (Conduent use only)

21. Provider Signature

22. Date