Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
All Provider Bulletin 152
April 2006

TO: All Providers Participating in MassHealth

FROM: Beth Waldman, Medicaid Director

RE: **Void Request Form for Non-Pharmacy Claims**

Current Procedure

MassHealth requires that a cover letter accompany all void requests submitted on paper in order to process the void request correctly. However, in many instances, these letters do not contain the information necessary to process voids accurately.

New Void Request Form

To improve this process, MassHealth has developed a new Void Request Form. The form, which is attached to this bulletin, eliminates the need for a cover letter. The Void Request Form contains the fields that must be completed for the request to be successfully processed: Date of Request, Claim Form Type, MassHealth Provider Number, Dollar Amount, Provider or Facility Name, Provider Address, and Void Reason.

Providers must continue to send the applicable MassHealth Remittance Advice(s) and any relevant information in addition to the Void Request Form.

Void requests with traditional cover letters will still be accepted. However, the new void request form is recommended to expedite your request.

Submitting Voids Electronically

MassHealth encourages providers to use the HIPAA-Compliant 837 Format Void and Replacement Transaction to void previously paid claims.

(continued on next page)

Requesting a Supply of the Void Request Form

This form is available for downloading on the MassHealth Web site at www.mass.gov/masshealth. Click on “MassHealth Regulations and Other Publications,” then on “Provider Library,” then on “MassHealth Provider Forms.” Or you may request a supply by writing to:

MassHealth
ATTN: Forms Distribution
P.O. Box 9118
Hingham, MA 02043
617-988-8974 (fax)

Photocopies of the Void Request Form will be accepted.

Questions

If you have any questions about the information in this bulletin please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

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Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Void Request Form

Paper Voids: To submit a paper void request, please complete this form and attach a photocopy of the **Remittance Advice (RA)** containing the claim lines to be voided. Please circle each claim line to be voided on the copy of the RA.

Send paper void requests to: MassHealth, ATTN: Voids, P.O. Box 9118, Hingham, MA 02043.

Please Note: Previously paid claims can be voided electronically in the HIPAA-Compliant 837 Format using the **Void and Replace Transaction**.

____
Date of Request

____
Claim Form Type

____
MassHealth Provider Number

____
Provider or Facility Name

____
Dollar Amount

____
Provider Address

Please check off one reason for requesting the void.

Please Note: If you need several claims voided for different reasons, please complete a request form for each reason and attach a copy of the RA indicating the claim line to be voided. A void request for several claims that are being requested for the same reason may be batched together with one request form.

- ☐ Collection from Medicare Part A
- ☐ Collection from Medicare Part B
- ☐ Collection from Medicare (not known if Part A or B)
- ☐ Collection from a commercial health insurance
  Name of insurance company ________________
  ____
- ☐ Collection from auto insurance or workers' compenstation insurance
- ☐ Claim paid to the wrong provider
- ☐ Wrong MassHealth member ID (RID) on the claim
- ☐ Provider billed incorrect service date
- ☐ Duplicate payment
- ☐ Collection from credit balance on patient account
- ☐ Provider performed only a certain component of the entire service billed
- ☐ Other (please explain): ____________________
  ____

The voided claim will be processed on a future remittance advice. The total amount originally paid will appear as a negative amount and that amount will be deducted from payments until the overpayment is recovered. If applicable, please follow the billing instructions found in your provider manual for resubmitting a replacement claim.

X____
Provider/Facility Authorized Signature

MassHealth appreciates your cooperation.