# VOID REQUEST FORM

Commonwealth of Massachusetts | Executive Office of Health and Human Services | www.mass.gov/masshealth

**Paper Voids:** To submit a paper void request for claims other than pharmacy and dental, please complete this form and attach a photocopy of the remittance advice (RA) containing the claims to be voided. Please circle each claim internal control number (ICN) to be voided on the copy of the RA.

If you need several claims voided for different reasons, please complete a separate Void Request Form for each reason and attach a copy of the RA indicating the claims to be voided. If you need several claims voided for the same reason, you may batch them together with one Void Request Form.

Send paper void requests to

MassHealth
ATTN: Voids
PO Box 7
Quincy, MA 02182-0007

**You can also void previously paid claims through the Provider Online Service Center using the HIPAA-compliant 837 format.**

| | |
|---|---|
| Date of Request | Claim Form Type |
| NPI or Provider ID/Service Location | Provider Name |
| Dollar Amount(s) | Provider Address |

## Please check one of the following reasons for requesting the void

- ☐ Collection from Medicare Part A
- ☐ Collection from Medicare Part B
- ☐ Collection from Medicare (not known if Part A or B)
- ☐ Collection from commercial health insurance
  Name of insurance company:
  _____
- ☐ Collection from auto insurance or workers' compensation insurance
- ☐ Claim paid to the wrong provider
- ☐ Wrong MassHealth member ID 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
- ☐ Provider billed incorrectly
- ☐ 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 MassHealth provider manual for resubmitting a replacement claim.

Provider Authorized Signature .....