UNIFORM BILLING ADJUSTMENT FORM

PAGE_____OF_____

PROGRAM NAME / SITE_____

CONTACT NAME_____

DATE OF REQUEST_____

FUNDING SOURCE TO BE ADJUSTED_____

BILLING PERIOD FOR ADJUSTMENT_____

BILLING REFERENCE	SOCIAL SECURITY NUMBER	DATE (MM/DD/YY)	CPT CODE	UNITS	TREATMENT TOTAL BILLED	CLIENT/3RD PTY PAID	CA PAID
Original billing paid as:					$	$	$
Correction needed:					$	$	$
						BALANCE DUE (+) OR OVERPAYMENT (-)	$

REASON FOR CORRECTION: _____

Original billing paid as:					$	$	$
Correction needed:					$	$	$
						BALANCE DUE (+) OR OVERPAYMENT (-)	$

REASON FOR CORRECTION: _____

Original billing paid as:					$	$	$
Correction needed:					$	$	$
						BALANCE DUE (+) OR OVERPAYMENT (-)	$

REASON FOR CORRECTION: _____

Original billing paid as:					$	$	$
Correction needed:					$	$	$
						BALANCE DUE (+) OR OVERPAYMENT (-)	$

REASON FOR CORRECTION: _____

Original billing paid as:					$	$	$
Correction needed:					$	$	$
						BALANCE DUE (+) OR OVERPAYMENT (-)	$

REASON FOR CORRECTION: _____

Original billing paid as:					$	$	$
Correction needed:					$	$	$
						BALANCE DUE (+) OR OVERPAYMENT (-)	$

REASON FOR CORRECTION: _____

TOTAL $ _____

PLEASE FAX COMPLETED UBA FORMS WITH COVER SHEET TO APPROPRIATE CMHSP:
West Michigan CMH (Lake, Mason, Oceana Counties) - 231-845-7095;
Muskegon - Attn: Brandy Carlson 231-724-1174;
Ottawa - Attn: Ryan McLatcher 616-393-5653 or by secure email to rmclatcher@miottawa.org