

TRUSTED
TMENT

PAGE _____ OF _____

PROGRAM NAME / SITE _____

CONTACT NAME _____ FUNDING SOURCE TO BE ADJUSTED _____

DATE OF REQUEST _____ 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