MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME______________________________________ CONTACT PERSON____

PROVIDER NUMBER____________________________________ TELEPHONE NUMBER ____

QUARTER ENDING: (Circle One) 3/31 6/30 9/30 12/31 YEAR _____________________________

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
	RECIPIENT'S NAME	MEDICAID NUMBER	FROM DATE OF SERVICE	TO DATE OF SERVICE	DATE MEDICAID PLAN	MEDICAID TCN	AMOUNT OF CREDIT BALANCE	CO-INSURANCE	C0-PAYMENT	DEDUCTIBLE	REASON FOR CREDIT BALANCE
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
11.											
12.											
13.											
14.											
15.											

Circle One: Refund Adjustment

DMA2044
Revised 08/16