**Instructions for Completing Medicaid Credit Balance Report**

Complete the "Medicaid Credit Balance Report" as follows:

- **Full name of facility as it appears on the Medicaid Records**
- **The facility's Medicaid provider number, the servicing provider's Medicaid number, facility's billing NPI number, and the servicing provider's NPI number**. **If the facility has more than one provider number, use a separate sheet for each number. DO NOT MIX**
- **Circle the date quarter end**
- **Enter year**
- The name and telephone number of the person completing the report. This is needed in the event South Dakota Medicaid has any questions regarding an item in the report

Complete the date fields for each Medicaid balance by providing the following information:

Column 1 – The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 – The individual Medicaid recipient identification number

Column 3 – The month, day, and year of beginning service (e.g., 12/05/20)

Column 4 – The month, day, and year of ending service (e.g., 12/10/20)

Column 5 – The date of Medicaid payment on the Remittance Advice (not the posting date)

Column 6 – The Medicaid claim number

Column 7 – The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 – The reason for the credit balance by entering: "01" if it is the result of any type of third party liability payment (health insurance payment, casualty insurance, or attorney payment) other than Medicare; "02" if it is a result of a Medicare payment; 07 in the event of a billing error. Please use "00" to denote any other type of credit balance and provide an explanation on the back of the form.

After this report is completed, total column 7 and mail to **Department of Social Services, Division of Medical Services, Program Integrity Unit, 700 Governors Drive, Pierre, SD 57501-2291**

# MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME:_____ CONTACT PERSON:_____

E-MAIL ADDRESS FOR CONTACT PERSON:_____ TELEPHONE NUMBER:_____

BILLING PROVIDER'S NPI:_____ SERVICING PROVIDER'S NPI_____

QUARTER ENDING: (Check one) ☐ 3/31 ☐ 6/30 ☐ 9/30 ☐ 12/31 YEAR:_____

| | (1) RECIPIENT'S NAME | (2) MEDICAID RECIPIENT ID NUMBER | (3) FROM DATE OF SERVICE | (4) TO DATE OF SERVICE | (5) DATE MEDICAID PAID | (6) MEDICAID CLAIM # | (7) AMOUNT OF CREDIT BALANCE | (8) REASON FOR CREDIT BALANCE |
|---|---|---|---|---|---|---|---|---|
| 1. | | XXXXXXXXXX | XX/XX/XXXX | XX/XX/XXXX | XX/XX/XXXX | | $100,000.00 | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |
| 7. | | | | | | | | |
| 8. | | | | | | | | |
| 9. | | | | | | | | |
| 10. | | | | | | | | |
| 11. | | | | | | | | |
| 12. | | | | | | | | |
| 13. | | | | | | | | |
| 14. | | | | | | | | |
| 15. | | | | | | | | |

(Only check one) ☐ Refund ☐ Adjustment (for TPL only)

**Return form and refund check to:**

Department of Social Services
Division of Medical Services
Program Integrity Unit
700 Governors Drive
Pierre, SD 57501-2291

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