

PAID CLAIM ADJUSTMENT REQUEST (PCAR) PAPER FORM INSTRUCTIONS

The PCAR form is used to process claims which were **previously paid**. If you are correcting the Dates of Service, Procedure Code, Days/Units, Billed Amount or Recouping a line or the entire Claim.

To Process a PCAR you need the following items:

1. A copy of the Remittance Advice (RA), which was attached to your check.
2. A PCAR form.
3. A copy of the original claim.

Line by line instructions:

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|-----|-----------------------------|---|
| 1. | Specialty | Leave Blank |
| 2. | NPI | Enter SWCAA'S NPI |
| 3. | RA Date | Enter Date, MM/DD/YEAR as it appears in the lower left |
| 4. | RA Number | Leave Blank |
| 5. | Client ID | Enter the client's Connecticut Medical Assistant Program ID number (9 digits) |
| | | |
| 6. | Client Name (Last, First) | Enter the client's name as it appears on the Claim |
| 7. | ICN/Internal Control Number | Enter the 13-digit ICN as it appears on the RA |
| 8. | Reason for Request | Check the appropriate box. |
| 9. | Claim Detail # | Copy claim line number from your original invoice . |
| 10. | Dates of Service | Copy Dates as they appeared on the original invoice . |
| | | |
| 11. | Procedure Codes | Copy Procedure Codes as they appeared on the original invoice . |
| 12. | Days/Qty/Units | Copy Days/Units as they appeared on the original invoice . |
| 13. | Billed Amount | Copy Billed Amount as they appeared on the original invoice . |

Boxes 14 – 20 should be BLANK

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| 21. | Claim Detail # | Copy claim line number from your original invoice . |
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Boxes 22 – 28 only fill in the information you are correcting

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| 30. | Provider Name | SWCAA |
| 31. | Street Address | 10 Middle Street 9 th Floor |
| 32. | City, State, Zip | Bridgeport, CT 06604-4229 |
| 33. | Authorized Signature | Your Signature |
| 34. | Date | Today's Date |

Upon Completion of PCAR form please make a copy for your files and MAIL ORIGINAL to SWCAA