# EEOICP Adjustment Request

1. Transaction Control Number (TCN) of the bill to be adjusted as shown on the Remittance Voucher

Claimant Information

2. Member ID Number

Claimant Name (Last, First, Initial)

Provider Information

3. Provider Number

Name

Address 1

Address 2

City ST Zip

Phone Number

Contact Person

4. Reason for adjustment (check all that apply)

- ☐ Keying Errors
- ☐ Incorrect charges
- ☐ Incorrect provider paid (Enter correct provider information in box 3)
- ☐ Incorrect unit of service
- ☐ Incorrect procedure code
- ☐ Incorrect diagnosis code/pointer
- ☐ Incorrect claimant id (Enter correct Claimant Number in box 2)
- ☐ Incorrect denial (authorization, proof of timely filing, and etc)

5. Explanation for Adjustment

Provider Signature_____Date _____

Note: All adjustments must be submitted in the following format:

- o Copy of original bill with the word “Adjustment” written at the top
- o The TCN of the paid or denied bill under the words “Adjustment”
- o Make the correction to the line item(s) billed in error
- o Please follow these steps to ensure more efficient processing of adjustments.

Please mail the completed adjustment request and supporting documentation to:
US Department of Labor - OWCP
P.O. Box 8304
London, KY 40742-8304