Void Request Form

Paper Voids: To submit a paper void request, please complete this form and attach a photocopy of the **Remittance Advice (RA)** containing the claim lines to be voided. Please *Circle* each claim line to be voided on the copy of the RA.

Send void requests to:

MassHealth Dental Program
Attn: MassHealth Voids
P.O. Box 612
Worcester MA 01613

Please note: Previously paid claims can be voided electronically in the HIPAA-Compliant 837 format using the void and replace transaction.

Date of Request

Provider or Facility Name

MassHealth Provider Number

Provider Address

Billing Provider's NPI#

Provider City, State, Zip

Amount

Please check off one reason for requesting the void

Please note: If you need several claims voided for different reasons, please complete a request form for each reason and attach a copy of the RA indicating the claim line to be voided. A void request for serval claims that are being requested for the same reason may be batched together with one request form.

- ☐ Collection from a Primary Health Insurance
  Name of Insurance Company: _____
- ☐ Collection from Auto Insurance of Worker's Compensation Insurance
- ☐ Claim paid to the wrong provider
- ☐ Wrong MassHealth member ID (MID) on the claim
- ☐ Provider billed incorrect service date
- ☐ Duplicate payment
- ☐ Provider performed only a certain component of the entire service billed
- ☐ Other (please explain): _____

The voided claim will be processed on a future remittance advice. The total amount originally paid will appear as a negative amount and that amount will be deducted from the payments until the overpayment is recovered. If applicable, please follow the billing instructions found in your provider manual for resubmitting a replacement claim.

Provider/Facility Authorized Signature

Date