LOUISIANA DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES FINANCING

MAIL TO:
DXC
P.O. BOX 91021
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040 (IN BATON ROUGE)

LONG TERM CARE
PATIENT LIABILITY ADJUSTMENT FORM

ADJUSTMENT

1 PROVIDER NO.	2 RECIPIENT I.D. NUMBER	3 RECIPIENT LAST NAME	4 FIRST NAME

5 LEVEL OF CARE	6 INITIATED BY BHSF LOCATION:

7 FROM DATE OF SERVICE	8 TO DATE OF SERVICE	9 TOTAL DAYS	10 INTERNAL CLAIM CONTROL NUMBER (ICN)	11 REVISED MONTHLY PATIENT LIABILITY	12 STATUS

13 **NAME OF BHSF REPRESENTATIVE** ______________________ **DATE** ______________________

14 **CONTACT PHONE NUMBER** ______________________

NOTE: This form can be completed and submitted only by a BHSF representative.

DXC 148/PLI
Revised 11/2018