Corrected Claim – Standard Cover Sheet

Health Plan: _____ **Product:** _____

Attention: _____ **Date Cover Sheet Prepared:** _____

CORRECTED CLAIM MUST BE ATTACHED

♦ **This is NOT a DUPLICATE claim. Please forward to the appropriate area for reprocessing.** ♦

Claim Identification Information: (*can't be processed without this number*)

Original Claim Number (from voucher): _____

Provider Office Contact Person:

Name: _____ Phone Number: _____

Other Information: _____

This claim is a corrected billing of a previous processed claim for the following reason(s):
(*can't be processed unless at least one of these boxes has been checked*)

- ☐ Corrected diagnosis
- ☐ Corrected date of service
- ☐ Corrected charges
- ☐ Corrected patient information
- ☐ Other: _____
- ☐ Corrected procedure code (CPT or CM)
- ☐ Addition, or correction, of modifier
- ☐ Corrected provider information

For each box checked above, please be specific about the correction that was made (e.g. corrected diagnosis, date of service, etc. along with associated claim line(s))

_____

_____

_____

_____

Only attach supporting documentation if REQUIRED by health plan

Supporting Documentation Attached? ◯ **Yes** ◯ **No**

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