

CLAIM CORRECTION FORM

Submitted to: Plan/Payer name: _____ Date submitted: ____ / ____ / ____

Plan/Payer address: _____
STREET SUITE CITY STATE ZIP

Telephone: (____) _____ Fax: (____) _____ E-mail: _____

Patient name: _____ Birth date: ____ / ____ / ____
FIRST M.I. LAST

Subscriber name: _____ Date of service: ____ / ____ / ____

Policy #: _____ Group #: _____ Original claim #: _____

Submitted by: Provider: _____ Contact: _____

Telephone: (____) _____ Fax: (____) _____ E-mail: _____

The following corrections were made on this claim:

- Patient's policy number/group number was incorrect. The correct number(s) are shown above.
- Date of service was incorrect. Correct date is: ____ / ____ / ____.
- CPT code was incorrect. Correct CPT code is _____ instead of _____.
- Diagnosis code was incorrect. Correct diagnosis code is _____ instead of _____.
- Visit was denied as over carrier's utilization limits. Please see attached letter to justify extensions of these limits.
- Procedure was denied as over carrier's utilization limits. Please see attached letter to justify extensions of these limits.
- Carrier indicated that the patient is covered by another plan that is primary. Patient indicates you are primary.
- Secondary carrier is _____. There is no secondary carrier.
- Procedure was denied as not medically necessary. Supporting documentation is attached.
- Carrier's clerk failed to enter correct number of times (units) procedure was performed. Correct units are as follows:
 DOS: ____ / ____ / ____ Code: _____ Units: _____ Charge total: \$ _____
- We failed to enter correct number of times (units) procedure was performed. Correct units are as follows:
 DOS: ____ / ____ / ____ Code: _____ Units: _____ Charge total: \$ _____
- Multiple surgical procedures: Carrier failed to approve any procedure at 100%. Carrier approved incorrect procedure at 100%.
 Carrier should have approved code _____ @ 100%/50% (circle one).
 Carrier should have approved code _____ @ 100%/50% (circle one).
 Carrier should have approved code _____ @ 100%/50% (circle one).
- Modifiers were omitted. Please reconsider as follows:

Code	Code	Code	Code
-50 _____	_____	-51 _____	_____
-58 _____	_____	-59 _____	_____
-79 _____	_____	-GA _____	_____
- E/M service was denied as included in the global surgical fee. Please reconsider with attached supporting documentation:
 Code: _____ Modifier(s): -24 -25 Charge: \$ _____
- UPIN information was omitted. Code: _____ Physician name: _____ UPIN: _____
- Plan-specific provider ID#: _____.
- CLIA number: _____.
- Place of service: _____.
- Service was rendered at the physician's physical location listed in Box 32 of the original claim form.
- EOB from primary carrier is attached.
- Incorrect information was entered on claim form. Line #: _____ Correct information: _____
- Other reason for correction: _____
- Comment: _____



FPM Toolbox To find more practice resources, visit <https://www.aafp.org/fpm/toolbox>.

Adapted from a form developed by the Plan-Provider Claims Workgroup convened by the American Association of Health Plans and the Healthcare Financial Management Association in cooperation with the Specialty Society Insurance Coalition. Copyright © 2016 American Academy of Family Physicians. Physicians may duplicate or adapt for use in their own practices; all other rights reserved. Related article: <https://www.aafp.org/fpm/20030700/19best.html>. Updated: February 2018.