

Claim Correction Form

Physician/Provider offices are encouraged to submit claims electronically. This form should be used in situations where the physician/provider cannot submit corrected claims electronically or where electronic submissions would not adequately address the issue.

Submitted To:

Plan/Payer Name: _____ Date Submitted: _____

Plan/Payer Address: _____

City: _____ State _____ Zip _____

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

Patient Name: _____ D.O.B.: _____
First M.I. Last

Subscriber Name: _____ Date of Service: _____

Policy #: _____ Group #: _____ Original Claim #: _____

Submitted From:

Physician/Provider Name: _____ TIN or ID #: _____

Contact: _____ Telephone: (____) _____ Ext. _____

Fax: (____) _____ E-mail: _____

THE FOLLOWING WAS CORRECTED ON THIS CLAIM:

- The patient's policy/group number was incorrect. The correct number(s) are shown above.
- The correct CPT code is _____ instead of _____
- Wrong date of service was filed. The correct date is _____
- Visits were denied based on the diagnosis given. Proper diagnosis code is _____ instead of _____
- Visit: Procedure: 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. This is incorrect. Patient indicates you are Primary.
- The secondary carrier is: _____ There is no secondary carrier.
- The procedure was denied as medically not necessary. Documentation to support the medical necessity of this service is attached.
- Our clerk: Carrier's clerk: failed to enter correct number of times (units) procedure was performed. Correct units are as follows:
 D.O.S.: _____ 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% or 50% instead of _____
 - Carrier should have approved code _____ @ 100% or 50% instead of _____
 - Carrier should have approved code _____ @ 100% or 50% instead of _____
- Modifiers should be attached to code(s)

Code	Code	Code	Code
<input type="checkbox"/> -50 _____	_____	<input type="checkbox"/> -51 _____	_____
<input type="checkbox"/> -58 _____	_____	<input type="checkbox"/> -59 _____	_____
<input type="checkbox"/> -79 _____	_____	<input type="checkbox"/> -GA _____	_____
<input type="checkbox"/> _____	_____	<input type="checkbox"/> _____	_____
- The following E/M visit was denied as included in the global surgical fee. In fact, the service was a significant separately identifiable service provided above and beyond the procedure and submitted with appropriate E/M modifier. Please reconsider with attached documentation:
 Code: _____ with modifier(s): -24 -25 Charge \$ _____
- UPIN information for code _____ was omitted. Physician/Provider Name: _____ UPIN: _____
- Plan specific physician/provider I.D. omitted. The I.D. # is _____
- CLIA number was omitted. The CLIA number is _____
- The place of service was incorrect. The place of service should be _____
- The service was rendered at the physician's/provider's physical location listed in Box 32 of the claim form.
- Failed to attach EOB from Primary carrier. The EOB is attached to this form.
- Failed to enter correct information on indicated line of claim form.
 Line #: _____ Correct Information: _____
- Other reason for claim correction: _____
- Comment: _____