**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: (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_ 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.

* + - 1.  Carrier’s clerk failed to enter correct number of times (units) procedure was performed. Correct units are as follows:

DOS: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Units: \_\_\_\_\_ Charge total: $ \_\_\_\_\_\_\_\_\_\_\_\_\_

* 1.  We failed to enter correct number of times (units) procedure was performed. Correct units are as follows:  
      DOS: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Units: \_\_\_\_\_ Charge total: $ \_\_\_\_\_\_\_\_\_\_\_\_\_
  2. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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. Physicians may adapt or photocopy for use in their own practices. “Best Practices in Claims Processing.” Backer LA. *Family Practice Management*. July/August 2003:19-22; www.aafp.org/fpm/20030700/19best.html.

