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: _____ / _____ / _____

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: _____

AAFP FPM

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

 Related article: https://www.aafp.org/fpm/2003/0700/p19.html. Updated: February 2018.