

# Claim Correction Form

Physician offices are encouraged to submit claims electronically. This form should be used in situations where the 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:**

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%/50% instead of \_\_\_\_\_  
 Carrier should have approved code \_\_\_\_\_ @ 100%/50% instead of \_\_\_\_\_  
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- Modifiers should be attached to code(s)
 

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- 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 name: \_\_\_\_\_ UPIN: \_\_\_\_\_
- Plan specific 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 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: \_\_\_\_\_