

Corrected Claim – Standard Cover Sheet

Health Plan: _____ Product: _____

Attention: _____

Date Cover Sheet Prepared: _____

◆ This is NOT a DUPLICATE claim. Please forward to the appropriate area for reprocessing. ◆

Be sure to attach the updated claim form!

Claim Identification Information:

Original Claim Number (from voucher): _____

Provider Office Contact Person:

Name: _____ Phone Number: _____

Other Information: _____

This claim is a corrected billing of a previous processed claim for the following reason(s):

- | | |
|--|---|
| <input type="checkbox"/> Corrected diagnosis | <input type="checkbox"/> Corrected procedure code (CPT or CM) |
| <input type="checkbox"/> Corrected date of service | <input type="checkbox"/> Addition, or correction, of modifier |
| <input type="checkbox"/> Corrected charges | <input type="checkbox"/> Corrected provider information |
| <input type="checkbox"/> Corrected patient information | |
| <input type="checkbox"/> Other: _____ | |

Any specific clarification/comment/instructions (e.g., the claim line that was corrected):

Supporting Documentation Attached? Yes No

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