CLAIM CORRECTION FORM

FPM Tool

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.

❍ 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: _____

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.

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