COMMUNITY HEALTH PLAN of Washington™

Corrected Claim – Standard Cover Sheet

Corrected claim: Represents a claim that was accepted and finalized (paid or denied) by Community Health Plan of Washington (CHPW). The claim is updated with additional information that may potentially impact the payment of the claim. Example: The initial claim submission is accepted and contains a single service line. The provider realizes lab charges were left off of the original claim and submits a corrected claim that contains the original billed services plus the new service lines with the lab charges.

If a claim was previously processed and is not submitted as a corrected claim, it will be denied as a duplicate claim.

CHPW encourages our providers to submit corrected claims electronically, rather than on paper; paper is needed only when the corrected claim requires an attachment. At this time, we are not able to accept attachments with electronic claims.

How to Submit Electronic Corrected Claims

Please complete the following steps when electronically submitting a corrected claim to CHPW in the ANSI-837 professional or institutional format.

- 837P (Professional) and 837I (Institutional) Claims: In Loop 2300 (Claim Information), segment CLM05-3, use Claim Frequency Type Code "7" for "Replacement." The corrected claim will process as a replacement claim and reverse the original claim on file.

How to Submit Paper Corrected Claims

Please complete this Corrected Claim – Standard Cover Sheet and attach your corrected claim form with your changes. To avoid a denial as a duplicate claim, include the claim indicator as follows:

- CMS 1500 (Professional Claim Form): Submit code 7 in box 22.
- UB-04 (Facility Claim Form): Submit Type of Bill ending in 7 in field 4 (Type of Bill).

Mail your completed cover sheet, corrected claim, and any supporting documentation to:

CHP Claims
PO Box 269002
Plano, TX 75026-9002

To avoid delays in processing your corrected claims, please do not send corrected claims to our Customer Service department.

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CORRECTED CLAIM INFORMATION

Privacy Statement: This document contains confidential information. Any disclosure, copying or distribution is prohibited. If you have received this information in error, please notify the sender and destroy all copies.

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

Date cover sheet prepared: _____ Product: ☐ Medicare ☐ Medicaid

Remember to attach the updated claim form!

Original claim number (from voucher /remit): _____

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

- ☐ Corrected diagnosis
- ☐ Corrected date of service
- ☐ Corrected place of service
- ☐ Corrected charges
- ☐ Corrected patient information
- ☐ Addition of NDC #
- ☐ Other: _____
- ☐ Corrected procedure code (CPT or HCPC)
- ☐ Addition or correction of modifier
- ☐ Corrected bill type
- ☐ Corrected provider information
- ☐ Addition of NPI

List specific changes/comments/instructions (such as the claim line that was corrected):

_____

_____

_____

Supporting Documentation Attached? ◯ Yes ◯ No

PROVIDER CONTACT INFORMATION

Name: _____

Phone Number (including area code): _____

Other Information: _____