SANTÉ COMMUNITY
PHYSICIANS

Corrected Claim – Standard Cover Sheet

Health Plan: ______________________ **Date Cover Sheet Prepared**: ____________________

Attention: **Cost Containment**

CORRECTED CLAIM MUST BE ATTACHED

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

Form Identification Information: (Can't be processed without this number)

Original Form Number (from EOB): _________________________ **Date of Service**:___________________

Provider Office Contact Person:

Name:_______________________________________ **Phone Number**:_____________________________

This claim is a corrected billing of a previously processed claim for the following reason(s): (Can't be processed unless at least one of these boxes has been checked)

- ☐ Corrected Diagnosis
- ☐ Corrected procedure code
- ☐ Corrected date of service
- ☐ Addition, or correction, of modifier
- ☐ Corrected Charges
- ☐ Corrected provider information
- ☐ Corrected patient information
- ☐ Other:____

For each checked box above, please be specific about the correction that was made (e.g. corrected diagnosis, date of service, etc. along with the associated claim line(s))

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