

### Physician/Supplier

**CORRECTED BILL (must attach corrected claim)**

*Diagnosis Code*     *Billed Charges*     *Procedure Code*     *EOB Attached*     *Interim/Final Bill*

**TIMELY FILING REVIEW (must attach proof of timely filing)**

*This form should not be used for submitting medical information; any medical information submitted with this form will be returned.*

*Please complete and return this form to the address shown above.*

*See bottom of form for important information.*

**SECTION 1 - PROVIDER INFORMATION**

Physician/Supplier Name	Provider #	Date
Address	Telephone #	
City, State and Zip Code	Provider Contact Name	

**SECTION 2 - PATIENT INFORMATION**

Patient Name	
Policyholder's Name	Policyholder's ID
Address	City, State and Zip Code

**SECTION 3 - ORIGINAL CLAIM INFORMATION**

Date of Service on Original Claim	Original Claim #	Total Charges on Original Claim \$
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**SECTION 4 - CORRECTED CLAIM INFORMATION**

Date of Service on Corrected Claim	Total Charges on Corrected Claim \$
Reason for Submission	
Provider Contact Signature	

Please Note: Claims which have been rejected/returned as UNPROCESSABLE (due to claims filing, eligibility or coding issues, etc.) or for which no claim number has been assigned are not subject to Corrected Billing. Those claims should be filed as original claims and should not have this form attached.