

CORRECTED CLAIMS REQUEST FORM

This form is to be completed if you are making an adjustment or correction to a HIP or CompreHealth claim that was denied for lack of or inaccurate information or was paid incorrectly.

1. Provide the claim number.
2. Select whether you are requesting an **adjustment** or **correction** to your original claim.
3. Provide the information requested within the adjustment or correction selection.
4. Complete the contact information.
5. Mail this completed form to the address provided below. (If you are making a correction, also mail the updated claim along with this form.)

Claim Number: _____

Adjustment Request

If the claim was denied in error, please provide the correct information:

- The referral number is: _____
- The prior approval number is: _____
- The member's coverage was reinstated.
- Other: _____

If the claim was paid incorrectly, please provide the correct information:

- Provider's ID number is: _____
- The member is _____, whose plan ID number is _____.
- The procedure code is: _____
- The charges are: _____
- The location is: _____
- The modifier is: _____
- The Coordination of Benefits primary or secondary coverage provider is: _____
- The date of service is: _____
- The rate is: _____
- Other: _____

Corrected Claim Request

If you submitted information in the original claim form that was incorrect, please provide a brief description of what has been corrected. Also, please attach a copy of the *corrected* CMS Professional 1500 or Facility UB92 claim form to this document.

Please give a brief description of what has been corrected on the attached claim.

Contact Information

In the event that we need to contact the requester, please provide the following information:

Date Requested: _____
Provider Name: _____
Contact Name: _____
Contact Phone: _____

Submit the completed form to:

EmblemHealth
P.O. Box 2845
New York, NY 10116-2845