

Corrected Claim Cover Letter

Cover letter for submitting a corrected or amended claim to a payer

PROVIDER INFORMATION

Date: [Today's Date]

Practice Name: [Your Practice Name]

Address: [Street, City, State, ZIP]

Phone: [Phone Number]

Fax: [Fax Number]

NPI: [NPI Number]

PAYER / INSURANCE COMPANY

Insurance Company: [Insurance Company Name]

Claims / Appeals Address: [Street, City, State, ZIP]

Fax: [Fax Number]

CLAIM REFERENCE

RE: CORRECTED CLAIM SUBMISSION

Patient Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Member / Policy ID: [Member ID]

Original Claim Number: [Original Claim Number]

Date of Service: [MM/DD/YYYY]

Corrected Claim Number: [Corrected Claim Number — if assigned]

Claim Frequency Code: 7 — Replacement of Prior Claim

LETTER BODY

Dear Claims Department,

Please find enclosed a corrected claim for the above-referenced patient and date of service. The original claim (No. [Original Claim Number]) was submitted on [Original Submission Date] and requires correction as outlined below.

SUMMARY OF CORRECTIONS

Field Corrected	Original Value	Corrected Value
Diagnosis Code (Box)	<u>[Original value]</u>	<u>[Corrected value]</u>

