# Billing Corrected Claims

## SUBMITTING CORRECTED CLAIMS

Corrected claims should only be submitted when information has changed. For example:

- Errors were found involving diagnosis, procedure, date, or modifier.
- Claims contained missing, incorrect, or incomplete data according to our claim submission criteria
- Services were missed in original submission.
- Post-adjudication audits detected incorrect diagnosis-related group or other billing errors.

### CORRECTING ELECTRONIC CLAIMS

Corrected Professional and Institutional claims may be submitted electronically by entering the original claim number in the notes and indicating Frequency code 7 as follows:

- Professional claims CMS -1500: Enter Frequency code 7 in Loop 2300 Segment CLM05-3
- Institutional claims UB-0 4: Submit with the last character of the Type of Bill as 7, to indicate Frequency code 7.

### CORRECTING PAPER CLAIMS

Corrected Professional and Institutional claims may be submitted on paper in the following way:

- Professional claims CMS -1500: Stamp or write “Corrected” on the CMS 1500 form.
- Institutional claims UB-04: Submit with the third digit of the Type of Bill as 7 (Replacement of Prior Claim) to indicate Frequency code 7.

## SUBMITTING CLAIMS

Claims may be submitted using a CMS-1500 or UB-04 claim form. All paper claims should be submitted to:

- Community Health Options, Mail Stop 200 (Medical and Behavioral Health claims), PO Box 1121, Lewiston, ME 04243.

Providers may also submit claims electronically through their clearinghouse or at www.Emdeon.com

- The Change Healthcare Payor ID to be used on medical claims submissions is 45341.
- The Change HealthCare Payor ID to be used on pediatric dental 02027

## CHECKING CLAIM STATUS AND ELIGIBLITY

Providers can contact Member Services for information about claim status, eligibility, and a variety of other services.

Member Services:

Business Hours Monday—Friday: 8:00AM—

6:00PM IVR available 24 hours a day/7 days per

week. Tele: (855)624-6463