

CORRECTED CLAIM SUBMISSION GUIDELINE

What is a corrected claim?

Providers should submit a corrected claim when the claim submitted previously was incorrect or incomplete. The previous claim must be in Paid or Denied status.

For example, the initial claim submission was accepted and contained a single service line. The provider later realized a service line was missing from the original claim. The provider should submit a corrected claim that contains the original billed services plus the new service line.

How to Submit Electronic Corrected Claims

Please complete the following indicators when submitting a corrected claim electronically to CCHP in the ANSI-837 professional or institutional format.

837P (Professional) and 837I (Institutional) Claims: In Loop 2300 (Claim Information), segment CLM05-3, use Claim Frequency Type Code “7” for “Replacement.” The corrected claim will process as a replacement claim and reverse the original claim on file.

The REF*F8 segment must include the original claim number ID, exactly as it appeared in the original claim being corrected—no additional characters.

How to Submit Paper Corrected Claims

Please complete the following indicators when submitting a corrected paper claim to CCHP.

CMS 1500 (Professional Claim Form): Submit code 7 in box 22.

UB-04 (Facility Claim Form): Submit Type of Bill ending in 7 in field 4 (Type of Bill). Enter the original claim number in Box 64.

Please also complete the Corrected Claim Cover Sheet when submitting a paper corrected claim. Mail your corrected claim form, cover sheet, and any supporting documentation to:

Contra Costa Health Plan
Attn: Claims Unit
595 Center Ave, Suite 100
Martinez, CA 94553

Guidelines:

- The corrected claim must be submitted according to the timely filing guideline (within 180 days from Date of Service)
- The corrected claim is used to replace the entire claim submitted previously
- The corrected claim should include all line items previously processed correctly. Reimbursement for line items no longer included on the corrected claim may be subject to recoupment by the plan
- A corrected claim does not constitute an appeal
- If a claim was previously processed and is not submitted as a corrected claim, it will be denied as a duplicate claim
- In some cases, medical records or other documentations may be required to justify corrections to diagnosis codes, DRGs, procedure codes, medication units, modifiers, or other modifications.

