

**ATTACHMENT 21**



**Corrected Claim Form**

Provider Name:	Date:
Member Name	Member ID
Claim Number:	Date of Service

<p>Reason for Corrected Claim: (Please check appropriate box)</p> <p><input type="checkbox"/> Correct Member Demographic</p> <p><input type="checkbox"/> Correct Billing Code (HCPC, CPT, Revenue Code or DRG)</p> <p><input type="checkbox"/> Correct Billing Modifier</p> <p><input type="checkbox"/> Correct Diagnosis Code (ICD9)</p> <p><input type="checkbox"/> Correct Provider Billing Information</p> <p><input type="checkbox"/> Other Insurance Payment (Attach EOB)</p> <p><input type="checkbox"/> Other (Use comments section to give detailed explanation)</p>
<p>Comments:</p>

Please mail completed form along with corrected claim and a copy of the **Denial** Remittance Advice to:

ATTN: Claims  
El Paso First Healthplans  
P.O. Box 971370  
El Paso Texas 79997

***\*A reminder all appeals of denied claims ad requests for adjustments on paid claims must be received by El Paso First within 120 days from the date of the Remittance Advice on which the claim appears.***