Chorus Community Health Plans
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CORRECTED CLAIM SUBMITTAL GUIDE

Submitting a correction to a previously processed claim.
Use this guide for examples on how to submit an electronic and/or paper corrected claim.

What is a corrected claim?

A corrected claim is any claim that has a change to the original claim, including but not limited to:

- Changes or corrections to charges
- Procedure or diagnostic codes
- Dates of service
- Member name

Corrected claim submittal requirements:

Corrected claims that do not include the required information listed below will be denied.

- All lines billed on the original claim must also be billed on the corrected claim, and in the same order
- All corrections require:
  - An appropriate Claim Frequency Code
  - Payer Claim Control Number (Original Claim ID)
  - Written reason of what was corrected. Paper HCFA claims box 19, paper facility UB claims box 80. Electronic claims: NTE* segment = Provider notes/remarks

Please note: The NTE segment allows for 80 characters. Please be very specific in what you are correcting on your claim or claim will be denied for lack of corrected claim information.

Examples:

- If adding/changing charges, please indicated which charges you are correcting.
- CPT/DX indicate the code you are correcting.

The following examples below show what information is required.

Example 1: A corrected claim that DOES NOT require supporting documentation.

	General Rule	837P & 837I	CMS-1500	CMS-1450
Claim Frequency Code	Must include one of the following: '7' - Replacement '8' - Void *Note: Corrected claims submitted with a '1' will be denied as duplicates*	Loop 2300: CLM05-3	Box 22 – Resubmission Code and Original Reference Number	Box 4 – Type of Bill Note: For Institutional claims, this represents the third digit of the Type of Bill being submitted
Payer Claim Control Number	Must include the original, CCHP claim number associated with the correction. CCHP claim numbers begin with a '20' and are 15 characters in length. *Note: Corrected claims without a CCHP formatted original claim ID will be rejected.*	Loop 2300: REF*F8	Box 22 – Resubmission Code and Original Reference Number	Box 64 – Document Control Number

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Supporting documentation may still be required for the following:

- Certain claim-edit denials related to code bundling
- New patient visits
- Global surgery
- Diagnosis
- Unlisted codes
- More

Submitters must submit claims requiring supporting documentation via the CMS-1500 or CMS-1450 form only. No electronic processing of these claims is currently supported. While CCHP can accept the paperwork (PWK) segment on an 837 transaction, we cannot guarantee it's being used in claims processing.

Example 2: A corrected claim that DOES require supporting documentation.

	General Rule	CMS-1500	CMS-1450
Claim Frequency Code	Must include one of the following: '7' - Replacement '8' - Void *Note: Corrected claims submitted with a '1' will be denied as duplicates*	Box 22 – Resubmission Code and Original Reference Number	Box 4 – Type of Bill Note: For Institutional claims, this represents the third digit of the Type of Bill being submitted
Payer Claim Control Number	Must include the original, CCHP claim number associated with the correction. CCHP claim numbers begin with a '20' and are 15 characters in length. *Note: Corrected claims without a CCHP formatted original claim ID will be rejected.*	Box 22 – Resubmission Code and Original Reference Number	Box 64 – Document Control Number

When to submit an appeal of a claim:
When a corrected claim doesn't address a claim denial, submit an appeal. Appeal can be submitted through the CCHP Provider Portal. To comply with HIPAA guidelines, please submit documentation that supports the correction only.