El Paso Health
Medicare Advantage

Corrected Claim Form

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

Reason for Corrected Claim:
(Please check appropriate box)

- ☐ Correct Member Demographic
- ☐ Correct Billing Code (HCPCS, CPT, Revenue Code or DRG)
- ☐ Correct Billing Modifier
- ☐ Correct Diagnosis Code (ICD-10)
- ☐ Correct Provider Billing Information
- ☐ Recoupment Request (Claim billed in error) Please provide claim number:_____
- ☐ Proof of timely filing (Please attach Remittance Advice or EDI Report)
- ☐ Other Insurance Payment (Attach EOB)
- ☐ Other (Use comments section to give a detailed explanation)

Comments:

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

ATTN: Claims
El Paso Health
P.O. Box 971370
El Paso, TX 79997

Reminder

All appeals of denied claims and requests for adjustments on paid claims must be received by El Paso Health within 120 days from the date of the Remittance Advice on which the claim appears.