Scripps
Health Plan Services

# Corrected Claim – Standard Cover Sheet

**Health Plan:** _____ **Product:** _____

**Attention:** _____ **Send to:** P.O. Box 2529 4S-300
La Jolla, CA 92038

**Date Cover Sheet Prepared:** _____ **FAX: 858-260-5852**

◆ **This is NOT a DUPLICATE claim. Please forward to the appropriate area for reprocessing.** ♦

Be sure to attach the updated claim form!

**Claim Identification Information:**

Original Claim Number (from voucher): _____

**Provider Office Contact Person:**

Name: _____ Phone Number: _____

Other Information: _____

**This claim is a corrected billing of a previous processed claim for the following reason(s):**

- o Corrected diagnosis
- o Corrected date of service
- o Corrected charges
- o Corrected patient information
- o Corrected procedure code (CPT or CM)
- o Addition, or correction, of modifier
- o Corrected provider information
- o Other: _____

**Any specific clarification/comment/instructions (e.g., the claim line that was corrected):**

_____

_____

_____

_____

**Supporting Documentation Attached?** o **Yes** o **No**

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