Scripps Health Plan

Corrected Claim – Standard Cover Sheet

Health Plan: _____ **Product:** _____

Attention: _____ **Send to:** P.O. Box 1928 4S-300
La Jolla, CA 92038

Date Cover Sheet Prepared:

♦ **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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