



El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

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.