CarePlus HEALTH PLANS

Submitting corrected claims

A corrected claim replaces a previously submitted claim and includes a change in the material information, which is information that could impact the way a claim is processed if that information were considered. If a healthcare provider identifies that a previously submitted claim is incorrect or incomplete, a corrected claim with accurate information should be submitted by following the steps outlined below.

Note: When seeking to remove a diagnosis code on a previously submitted Medicare claim, the provider should follow an additional process to submit a diagnosis code deletion request. For more information on this process, please email an inquiry to CPHP_MRAProviderDeleteRequests@careplus-hp.com.

Submitting via Availity Essentials:
Correcting claims online via Availity Essentials:

1. Sign in to Availity Essentials. If you are not registered with Availity Essentials, go to **www.availity.com**, select "Get Started" in the upper right corner and follow the instructions.
2. Select "Claims & Payments" from the navigation bar at the top.
3. Select "Claim Status" and search for the claim you want to correct. If you don't see the "Claim Status" option, contact your Availity Essentials administrator to request access to this tool.
4. If the claim can be corrected, a "Correct this Claim" button will display on the claim detail screen. Select the button, make corrections as needed and submit the correction.

Submitting via your clearinghouse:
Submit your corrected claim through your clearinghouse.

Correcting claims using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Health Care Claims ASC X12 format (electronic method)

Professional 837P – ASC X12 format: Loop 2300

Segment: CLM (claim information)	
• CLM01 (claim submitter's identifier)	
• CLM02 (monetary amount)	
• CLM05 (healthcare service location information)	
– CLM05 – 1 (facility code value)	*Place of service code
– CLM05 – 2 (facility code qualifier)	*Place of service codes for professional or dental services
– CLM05 – 3 (claim frequency type code)	*For corrected claim, populate with a value of 7 Frequency of 7 must have the "Original Reference number" on REF01
• CLM06 (yes/no condition or response code)	*Physician or supplier signature indicator
• CLM07 (physician accepts assignment code)	*Assignment or plan participation code
• CLM08 (yes/no condition or response code)	*Benefits assignment certification indicator
• CLM09 (release of information code)	
Segment: REF (Payer claim control number)	
• REF01 (reference identification qualifier)	*F8
• REF02 (reference identification)	*Payer claim control number

(Continued on next page)

Institutional 837I – ASC X12 format: Loop 2300

Segment: CLM (claim information)	
• CLM01 (claim submitter's identifier)	
• CLM02 (monetary amount)	
• CLM05 (healthcare service location information)	
– CLM05 – 1 (facility code value)	*Facility type code
– CLM05 – 2 (facility code qualifier)	*Uniform billing claim form bill type
– CLM05 – 3 (claim frequency type code)	*For corrected claim, populate with a value of 7 Frequency of 7 must have the "Original Reference number" on REF01
• CLM07 (physician accepts assignment code)	*Assignment or plan participation code
• CLM08 (yes/no condition or response code)	*Benefits assignment certification indicator
• CLM09 (release of information code)	
Segment: REF (payer claim control number)	
• REF01 (reference identification qualifier)	*Original reference number F8
• REF02 (reference identification)	*Payer claim control number

Correcting claims using paper claim forms (paper method)

Professional claims: CMS 1500	Institutional claims: UB-04
• Stamp "Corrected Claim" on the CMS 1500 form • Populate "Resubmission Code" (box 22) with a value of 7 • Populate "Original Reference Number" (box 22) with the claim number from original claim • **Do not use red ink when creating a paper claim**	• Submit with the third digit of type of bill as 7 to indicate frequency code • Populate "Document Control Number" (box 64) with the claim number from original claim • **Do not use red ink when creating a paper claim**

More information

Please note, CarePlus prefers to receive corrected claims electronically.

If you have additional questions about corrected claims, please follow industry guidance according to the Health Care Claim Implementation Guide, using 837P for professional claims or the 837I for institutional claims.

For more information on HIPAA X12 837 Health Care Claim transactions, please visit the Washington Publishing Company website at **https://wpc-edi.com**.