Corrected Claim Submission Form

Do not use this form to re-submit a claim that was previously denied.
Use of this form is not required for re-submission of a denied claim.

Instructions

Use this form to submit a corrected, previously paid claim. See your Alliance Provider Manual and/or Alliance Policy 600-1009 - Corrected Claim Submissions for more information on the submission of corrected claims.

Part 1: Provider information

Provider Name: _____ TAX/NPI#: _____

Street: _____ City: _____

State: _____ Zip Code: _____

Member Name: _____ Member ID:_____

Your Name:_____

Part 2: Claim Information

Please provide corrections or additional information necessary to reconsider the previously paid claim.

Claim Control Number (CCN) and Line Number(s): _____

What is being corrected? Why? Please state clearly and precisely:

Please remember to include with this form:

- A copy of the corrected claim
- Additional information or attachments as necessary

Return this form

Mail to:
Central California Alliance for Health, Attn: CORRECTED CLAIMS
P.O. Box 660015, Scotts Valley, CA 95067-0015.