

## Claim Correction Request Form

Please attach a copy of the corrected claim form reflecting the changes noted below, and list any clarifications or special instructions in the additional comments. No new claims should be submitted with this form. Do not use this form for formal appeals or disputes. Continue to use the standard appeals process for formal appeals or disputes.

Patient Name:			
Member ID #:	D.O.S.:	Claim #:	
Provider Name:	N.P.I. #:		
Contact Name:	Phone:	Fax:	

### Reason for Correction

**Please attach a corrected claim and all required supporting documentation.**

Additional charges/services	Documentation to support modifier 25 or 59 (bundled claim)
Canceled charges/Retraction request	Invoice/MSRP or other records for pricing
Corrected date of service	NDC number
Corrected diagnosis code	Quantity correction
Corrected modifier	Other: _____
Corrected procedure code	

Additional Comments:

### Please return this form with supporting documentation to:

Health Plan of San Mateo  
**Attention Claim Corrections**  
801 Gateway Blvd. Suite 100  
South San Francisco, CA 94080  
**Fax: (650) 829-2051**

If you have any questions about corrected claims, you can contact HPSM's Claims Department Directly at **650-616-2056**, or by e-mail at [claimsinquiries@hpsm.org](mailto:claimsinquiries@hpsm.org).

Providers are encouraged to correct and rebill denied claims instead of using the claim correction process when possible to expedite reimbursement.

When HPSM denies a claim or service line due to incorrect information on the initial claim form, a new claim form should be submitted addressing the issue that triggered the denial. More information is available at [www.hpsm.org](http://www.hpsm.org).