

<p><b>Check one:</b></p> <p><input type="checkbox"/> RAF</p> <p><input type="checkbox"/> TAR</p> <p><b>Instructions for Provider</b></p> <p>1) Please complete the form to submit corrections on a previously submitted RAF or TAR.</p> <p>2) Fax to HPSM at (650) 829-2079.</p> <p>3) Incomplete or illegible forms will be returned.</p>	<p><b>DATE OF CORRECTION</b></p> <p>__ / __ / __</p>	<p><b>TAR / RAF NUMBER</b></p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
	<p><b>PROVIDER NAME</b></p> <p>_____</p>	<p><b>PROVIDER NUMBER</b></p> <p>_____</p>	
	<p><b>PROVIDER PHONE NUMBER EXT.</b></p> <p>(__ __ __) _____ - _____</p>	<p><b>PROVIDER FAX NUMBER</b></p> <p>(__ __ __) _____ - _____</p>	
	<p><b>PATIENT NAME</b></p> <p>_____</p>		
	<p><b>MEMBER ID NUMBER</b></p> <p>_____</p>	<p><b>DATE OF BIRTH</b></p> <p>__ / __ / __</p>	

Please check desired changes. If applicable, use the space provided to state specific information.

- ADD MODIFIER \_\_ \_\_ TO PROCEDURE CODE \_\_\_\_\_
  
- CHANGE MODIFIER FOR PROCEDURE CODE \_\_\_\_\_ ; NEW MODIFIER \_\_ \_\_
  
- CHANGE PROCEDURE CODE:
  - OLD \_\_\_\_\_
  - NEW \_\_\_\_\_
  
- CHANGE DATE OF SERVICE:
  - \_\_ / \_\_ / \_\_ TO \_\_ / \_\_ / \_\_
  
- CHANGE PROVIDER ID#
  
- CHANGE FACILITY ID#
  
- CHANGE NUMBER OF UNITS FOR PROCEDURE CODE \_\_\_\_\_ TO \_\_\_\_\_
  
- OTHER CORRECTION, PLEASE EXPLAIN:

**COMMENTS FOR HPSM REVIEWER:**

**CONTACT PERSON:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_