HealthPlan OF SAN MATEO
Healthy is for everyone

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

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** .