

### Physician/Supplier

 **CORRECTED BILL (must attach corrected claim)**

*Diagnosis Code*   
  *Billed Charges*   
  *Procedure Code*   
  *EOB Attached*   
  *Interim/Final Bill*

 **TIMELY FILING REVIEW (must attach proof of timely filing)**

*This form should not be used for submitting medical information, any medical information submitted with this form will be returned.*

*Please complete and return this form to the address of the applicable health plan check below.  
 See bottom of form for important information*

Please check (✓) one   
 ABCBS   
 BlueCard   
 Health Advantage   
 Blue Advantage   
 FEP

SECTION 1 - PROVIDER INFORMATION		
Physician/Supplier Name	Provider #	Date
Address	Telephone #	
City, State and Zip Code	Provider Contact Name	

SECTION 2 - PATIENT INFORMATION	
Patient Name	
Policyholder's Name	Policyholder's ID <i>(Please include alpha prefix)</i>
Address	City, State and Zip Code

SECTION 3 - ORIGINAL CLAIM INFORMATION		
Date of Service on Original Claim	Original Claim #	Total Charges on Original Claim \$
	BlueCard SCCF#	

SECTION 4 - CORRECTED CLAIM INFORMATION	
Date of Service on Corrected Claim	Total Charges on Corrected Claim \$
Reason for Submission	

Provider Contact Signature
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Please Note:    Claims which have been rejected/returned as UNPROCESSABLE (due to claims filing, eligibility or coding issues, etc.) or for which no claim number has been assigned, are not subject to Corrected Billing. Those claims should be filed as **original** claims and should not have this form attached.