Submitting a Corrected Claim

PH Tech will not be able to accept requests submitted by providers to change required data elements to a claim via email, either directly to PH Tech staff or via CIM link, in order to obtain payment for that claim. Instead, providers will be required to submit a corrected claim reflecting needed changes either by paper or electronically as applicable.

When submitting a corrected claim, you will need to re-submit the ENTIRE claim with any necessary corrections. If you submit only the corrected data and not the entire claim, your claim may not be processed correctly.

Corrected claims MUST be submitted to PH Tech within 365 calendar days of the original adjudication date.

Corrected Paper Claims

1. Do not over-write or hand write changes to the original claim as these **will not be accepted**

2. Create a new claim with applicable changes, noting in the top margin that the claim is a corrected claim

   - Regarding bill type and box 22:
     - In many situations the 4th digit of the bill type represents the frequency of bill
     - For inpatient, outpatient and SNF fourth digit = 0, 1, 2, 3, 4, 7, 8 (frequency of bill) Home health the fourth digit = 2, 7, 8, 9 (frequency of bill)

       0 = Nonpayment/zero claim

       1 = Admit-through-discharge claim

       2 = Interim – First claim

       3 = Interim – Continuing claim

       4 = Interim – Last claim

       7 = Replacement of prior claim

       8 = Void/cancel of a prior claim

       9 = Final claim for a home health PPS episode
     - For professional claims, the industry standard is to have the frequency code left justified in box 22

3. Submit the paper claim as you would a new claim

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Corrected Electronic Claims

1. If submitting a corrected claim through electronic billing, the following loop information should be referenced:

   - Loop 2300 Claim Information

     – Segment CLM05-03 Claim Frequency Type Code - inserting a value of "7" indicates that the claim is a replacement of the original (facility claims only)

     – Segment REF-Payer Claim Control Number (these two segments correspond to CMS 1500 form, box 22a and 22b)

       – REF01 – Reference Identification Qualifier, inserting a value of "F8" indicates original reference number

       – REF02 – Reference Identification or Payer Claim Control Number, the original claim number should be listed