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

*Last Revised: September 2019*
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