

### Institutional Corrected Claim Form (Minnesota)

Member Information	
Member name:	Member ID#:
Provider name:	Provider legacy ID#:
Admission date:	
From (date):	Thru (date):
Original claim #:	Billed charge:

Provider Information	
Provider contact name:	Phone:
E-mail:	Fax:

Check box and indicate reason for correction:									
Check one: <input type="checkbox"/> Late Charge <i>OR</i> <input type="checkbox"/> Late Credit									
Rev Code		HCPCS/CPT		Date of Service		Units		Amount	\$
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Rev Code		HCPCS/CPT		Date of Service		Units		Amount	\$
Rev Code		HCPCS/CPT		Date of Service		Units		Amount	\$
Total charges of original claim								\$	
Corrected total charges								\$	

<input type="checkbox"/> Date of service incorrect. Correct date is: ____/____/____.
<input type="checkbox"/> Rev code incorrect. Change Rev Code to _____ instead of _____.
<input type="checkbox"/> CPT/HCPCS code incorrect. Change CPT/HCPCS code to _____ instead of _____.
<input type="checkbox"/> Diagnosis code incorrect. Change diagnosis code to _____ instead of _____.
<input type="checkbox"/> Diagnosis code missing. Add diagnosis code _____
<input type="checkbox"/> Billed in error. Change facility from _____ to _____.
<input type="checkbox"/> Billed in error because _____
<input type="checkbox"/> Other: _____

**Attach this form to paper copy of corrected claim and mail to:**  
**\*\*ALERT: You must attach a paper copy of the corrected claim to this form. If a corrected copy of the claim is not attached, this request will not be considered.**

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 BCBS of Minnesota  
 P.O. Box 64338  
 St. Paul, MN 55164-0338