



# MedicareBlue<sup>SM</sup> PPO

A Medicare Advantage Plan

## Professional Corrected Claim Form (North Dakota)

Member Information	
Member name:	Member ID#:
Provider name:	Provider legacy ID#:
Date of service:	
Billed charge:	Original claim #:

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

Check box and indicate reason for correction:
<input type="checkbox"/> Add modifier _____ to CPT/HCPCS _____. <input type="checkbox"/> Date of service incorrect. Correct date is: ____/____/____. <input type="checkbox"/> Change dollar amount to _____ instead of _____. <input type="checkbox"/> Remove/change procedure code _____. Change to _____. <input type="checkbox"/> Diagnosis code incorrect. Change diagnosis code to _____ instead of _____. <input type="checkbox"/> Diagnosis code was missing. Add diagnosis code _____. <input type="checkbox"/> Place of service was incorrect. Change to _____ instead of _____. <input type="checkbox"/> Change individual practitioner ID# to _____ instead of _____. <input type="checkbox"/> Change units as follows: DOS: ____/____/____ CPT/HCPCS: _____ Units: _____ Charge total: \$ _____. <input type="checkbox"/> Billed in error. Services should not have been billed 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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