

- An original red and white institutional (UB-04) claim must be typed, not handwritten, and contain a corrected (replacement) or voided bill type in Field 4, as well as the original claim number in Field 64.
- An original red and white professional (CMS-1500) claim must be typed, not handwritten, and contain Resubmission Code “7” for a corrected (replacement) claim, or an “8” for a voided claim, and the original claim number in Field 22.
 - ✘ A claim that is a copy, is handwritten, or is missing the correct type of bill or resubmission code and/or the original claim number will be rejected or denied.

Instructions:

1. This form should only be used to make a correction, such as a change in diagnosis code or amended charges, or to void a **previously processed** claim. It should ***not*** be used to resubmit a rejected claim or to verify claim status.
2. Do not write, stamp, staple, or use correction fluid on the claim form.
3. This form must accompany your corrected or voided claim to ensure accurate processing. Please complete all fields below, and use one (1) form per claim.

4. Please complete all of the following, USING A SEPARATE FORM FOR EACH CLAIM:

Date of correction/void request			
Member Name & ID #			
Date(s) of service			
Claim number to replace or void			
Claim type	Replacement (7)	Voided (8)	(Choose one)
Provider Name, NPI# & Address			
Provider Phone # & E-mail			
Copy of Remittance Advice attached	Y	N	(Choose one)

5. The claim has been corrected to reflect a change in one of the following, or should be voided:

- | | |
|--|--|
| <input type="checkbox"/> Date of Service | <input type="checkbox"/> Originally-billed Charges |
| <input type="checkbox"/> Place of Service | <input type="checkbox"/> Additional information (EOB, Letter of Agreement, etc.) |
| <input type="checkbox"/> Diagnosis Code | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> CPT or HCPCS Code | <input type="checkbox"/> VOIDED Claim |
| <input type="checkbox"/> Modifiers | |
| <input type="checkbox"/> Units | |

**6. Please mail completed form and claim to: Neighborhood Health Plan of RI
PO Box 28259
Providence, RI 02908-3700**

If you have any questions, please contact Provider Services at (800) 963-1001. Thank you.