Corrected (Replacement)/Voided Claim Request Form

Neighborhood Health Plan OF RHODE ISLAND™

910 Douglas Pike, Smithfield, RI 02917 : 1-800-963-1001 : nhpri.org

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- Please refer to our Provider Manual for the requirements and filing limits of a Corrected Claim submission.

- Paper submissions will be rejected, denied, or returned to a participating provider unless supporting documentation is required for the claim submission (except self-identified audits > 365 days from date of service).
- Paper submissions will be accepted for a non-participating provider.
- A claim that is a copy, is handwritten, or is missing the correct type of bill or resubmission code and/or the claim number to replace/void will be rejected, denied, or returned to the provider.

☐ **Self-Identified Audit-** Check this box if you are correcting an overpayment greater than 365 days from the date of service.

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 adjudicated** 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 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:**

- ❑ Date of Service
- ❑ Place of Service
- ❑ Diagnosis Code
- ❑ CPT or HCPCS Code
- ❑ Modifiers
- ❑ Units
- ❑ Originally-billed Charges
- ❑ Additional information (EOB, Single Case Agreement, etc.)
- ❑ Other: _____
- ❑ VOIDED Claim

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.