

Corrected (Replacement)/Voided Claim Request Form

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

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



- Paper submissions will be accepted from non-participating providers.
- Paper submissions will be rejected, denied, or returned to *participating* providers unless supporting documentation that cannot be communicated on a claim form is required for the claim submission (except self-identified audits >365 days from date of service).
- 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 more 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) <input type="checkbox"/>	Voided (8) <input type="checkbox"/>	(Choose one)
Provider Name, NPI# & Address			
Provider Phone # & E-mail			

**5. 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.