Illinois Corrected Claim Form – Standard Cover Sheet

Participating providers have 90 days from the date of the original remittance advice to submit corrected claims.
Non-participating providers have 365 days from the date of service to submit corrected claims.

Be sure to attached the updated claim form

This is **not** a duplicate claim.
Please submit to:
Molina Healthcare of Illinois
P.O. Box 540
Long Beach, CA 90801

Original Claim Number (from Remittance Advice, if any): _____

Provider Office Contact Information

Contact Name:	
Telephone Number: ( )	Date Completed:
Other Information:	

This claim is a corrected billing of a previously processed claim for the following reason(s):

- ☐ Corrected Diagnosis
- ☐ Corrected Procedure Code (CPT/HCPCS)
- ☐ Corrected Date of Service
- ☐ Addition or Correction of Modifier
- ☐ Corrected Charges
- ☐ Corrected Provider Information
- ☐ Corrected Patient Information
- ☐ Corrected Last Menstrual Period Date
- ☐ Corrected EPSDT Indicator
- ☐ Other:

Any specific clarification/comment/instructions (e.g., the claim line that was corrected):

_____

_____

_____

Supporting Documentation Attached?

- ☐ Yes
- ☐ No