



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 attach 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

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