



## 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):**

- |  |   |
|--|---|
| <input type="checkbox"/> Corrected Diagnosis           | <input type="checkbox"/> Corrected Procedure Code (CPT/HCPCS) |
| <input type="checkbox"/> Corrected Date of Service     | <input type="checkbox"/> Addition or Correction of Modifier   |
| <input type="checkbox"/> Corrected Charges             | <input type="checkbox"/> Corrected Provider Information       |
| <input type="checkbox"/> Corrected Patient Information | <input type="checkbox"/> Corrected Last Menstrual Period Date |
| <input type="checkbox"/> Corrected EPSDT Indicator     | <input type="checkbox"/> Other:                               |

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

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### Supporting Documentation Attached?

- ☐ Yes ☐ No

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