Chorus Community Health Plans
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CCHP Corrected Claim Submittal Guide

Here at Chorus Community Health Plans (CCHP), we know and understand that it may be necessary to submit a correction to a previously processed claim. This guide includes instructions on how to submit your corrected claim in either an electronic or paper format. Most corrected claims can be submitted using an electronic format. However, CCHP may require supporting documentation in a paper format for corrections made as a result of a coding denial.

What is a corrected claim?

A corrected claim is any claim that has a change to the original claim, including but not limited to:

- Changes or corrections to charges
- Procedure or diagnostic codes
- Dates of service
- Member name

Corrected claim submittal requirements

Corrected claims that do not include the required information listed below will be denied.

- All lines billed on the original claim must also be billed on the corrected claim, and in the same order
- All corrections require:
  1. An appropriate Claim Frequency Code
  2. Payer Claim Control Number (Original Claim ID)

The following examples below show what information is required.

Example 1: A corrected claim that DOES NOT require supporting documentation.

	General Rule	837P & 837I	CMS-1500	CMS-1450
Claim Frequency Code	Must include one of the following: • '7' - Replacement • '8' - Void Note: Corrected claims submitted with a '1' will be denied as duplicates	Loop 2300: CLM05-3	Box 22 – Resubmission Code and Original Reference Number	Box 4 – Type of Bill Note: For Institutional claims, this represents the third digit of the Type of Bill being submitted
Payer Claim Control Number	Must include the original, CCHP claim number associated with the correction. CCHP claim numbers begin with a '20' and are 15 characters in length. Note: Corrected claims without a CCHP formatted original claim ID will be rejected.	Loop 2300: REF*F8	Box 22 – Resubmission Code and Original Reference Number	Box 64 – Document Control Number

Example 2: A corrected claim that DOES require supporting documentation. Supporting documentation may still be required for the following:

- Certain claim-edit denials related to code bundling
- New patient visits
- Global surgery
- Diagnosis
- Unlisted codes
- More

Submitters must submit claims requiring supporting documentation via the CMS-1500 or CMS-1450 form only. No electronic processing of these claims is currently supported. While CCHP is able to accept the paperwork (PWK) segment on an 837 transaction, we cannot guarantee it's being used in claims processing.

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When to submit an appeal of a claim denial

CCHP asks that you submit an appeal when a corrected claim doesn't address a claim denial. Submitters must send a completed Code Review Request Form (available on our website); along with any more required supporting documentation. To comply with HIPAA guidelines, please submit documentation that supports the correction only.

We're here to help

If you have questions or need assistance, please call a CCHP Provider Relations Representative at 844-229-2775.