Submitting corrected claims

Simply Healthcare Plans, Inc. will treat corrected claims as replacement claims. When you submit a corrected claim, it is important that you clearly identify that the claim is a correction rather than an original claim. Refer to the instructions below for information on submitting *CMS-1500* and *UB-04* claims forms.

Electronic *CMS-1500* claims
Enter Claim Frequency Type code (billing code) 7 for a replacement/correction. Enter 8 to void a prior claim in the 2300 loop of CLM*05 03. Enter the original claim number in the 2300 loop of the REF*F8*.

Paper *CMS-1500* claims
Simply will accept:

- *Corrected claim* written on the face of the *CMS-1500* claim.
- The *Provider Adjustment Request Form* clearly identifying the information being corrected.
- Entry in box 22 of the claim:
    - Use resubmission code 7 to notify us of a corrected or replacement claim.
    - Insert an 8 to let us know you are voiding a previously submitted claim.
    - Enter the original claim number in the Original Ref. No. field. If that information is not available, enter the original document control number (DCN).

Electronic or paper *UB-04* claims

- Simply will continue to accept the *Provider Adjustment Request Form* clearly identifying the information being corrected.
- When submitting a corrected claim, ensure the type of bill is xx7 (correction/replacement) or xx8 (void) when the correction is made within the initial claim one year timely filing limitation.

When you need to correct a claim and it is *beyond* the timely filing limit of one calendar year from the through date on claim, you should resubmit a reopening request (type of bill XXQ) to correct the error. Reopenings are typically used to correct claims with clerical errors, including minor errors and omissions, and are conducted at the discretion of the plan. Therefore, it is not appealable and the original initial determination stands as a binding decision. Appeal rights are retained on the original initial determination. Omissions do not include failure to bill items or services such as late charges.

Note: For adjustments and reopenings that result in higher weighted diagnosis-related groups (DRGs) there is a congressionally mandated time frame of 60 days from the initial claim determination.