

WPS CORRECTED CLAIMS

This form must be completed and attached to your corrected claim. **Requests submitted without a completed form will be returned.** You must identify the information being changed or corrected, explain why the change or correction is being requested and provide supporting documentation as necessary.

Provider Name:	Date Prepared:
Contact Name:	Phone Number:

Member Name:	Member Number:
Date of Service:	Original Claim Number:

Reason(s) for Corrected Claim:

(Please check appropriate box(es))

- Corrected diagnosis
- Corrected date of service
- Corrected charges
- Corrected patient information
- Corrected billing code (HCPC, CPT, Revenue Code or DRG)
- Addition, or correction, of modifier
- Corrected provider information
- Other: _____

For each box checked above, please be specific about the correction that was made and justification:

- Supporting documentation attached.

Please mail completed form along with corrected claim and supporting documentation, as applicable, to the below address.

New address for paper claim submissions

If you previously submitted claims to P.O. Box 981641, El Paso, TX, please use the address below, effective Aug. 1, 2016, for all paper claims and claim-related correspondence.

WPS Health Insurance
P.O. Box 21341
Eagan, MN 55121