WPS HEALTH INSURANCE

FAMILY CARE/CLTS CORRECTED CLAIM FORM

(ONE CLAIM PER FORM)

THIS FORM CAN ONLY BE USED FOR CORRECTIONS TO PAID OR PARTIALLY PAID SERVICES – IF CLAIM WAS DENIED IN FULL, SUBMIT AS A NEW CLAIM TO WPS

Claims denied in full for reason code as duplicate, please contact the appropriate WPS Contact Center listed below for resolution.

BILLING PROVIDER NAME:	
TAX ID (EIN or SSN):	
BILLING ADDRESS:	
PHONE NUMBER**:**	

MEMBER/PARTICIPANT ID:	
MEMBER /PARTICIPANT (LAST NAME, FIRST NAME):	
ORIGINAL CLAIM NUMBER: *If not provided, this form will be returned.*	

YOU MUST CHECK AND COMPLETE ALL BOXES THAT ARE APPLICABLE AND ATTACH YOUR PROVIDER REMITTANCE ADVICE – IF NOT COMPLETED, THE FORM WILL BE RETURNED.

☐ **CLAIM PARTIALLY PAID AND PARTIALLY DENIED WITH REASON CODE 'FAE'**
AUTHORIZATION MUST BE UPDATED PRIOR TO SUBMISSION OF CORRECTED CLAIM FORM

☐ **MEDICARE OR OTHER INSURANCE HAS MADE AN ADJUSTMENT TO A PRIOR PAYMENT**
REPROCESS THE PAID CLAIM USING THE ATTACHED MEDICARE OR OTHER INSURANCE EOB

◯ **INCREASE OR** ◯ **DECREASE**

BILLED AMOUNT	**ORIGINAL AMOUNT**		**NEW AMOUNT**	
UNITS BILLED	**ORIGINAL UNITS**		**NEW UNITS**	

☐ **CHANGE TO:** **REASON FOR CHANGE: _____**

DATE OF SERVICE	**ORIGINAL DATE**		**NEW DATE**	
AUTHORIZATION	**ORIGINAL AUTH**		**NEW AUTH**	
CPT/HCPCS/REV	**ORIGINAL CODE**		**NEW CODE**	

Additional comments regarding reason for correction:

Bureau of Children's Services CLTS Waiver
c/o WPS Health Insurance
P.O. Box 211597
Eagan, MN 55121
(877) 298-1258

Family Care
c/o WPS Health Insurance
P.O. Box 211595
Eagan, MN 55121
(800) 223-6016