

**WPS 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Additional comments regarding reason for correction:**

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

|  |  |
| --- | --- |
| **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 |