

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: <i>If not provided, this form will be returned.</i>	

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