



# CORRECTED CLAIM – Standard Cover Sheet

This is NOT a DUPLICATE claim. Please submit to:  
Molina Healthcare, Inc.  
PO Box 22712  
Long Beach, CA 90801

## Be sure to attach the updated claim form!

Participating providers have 120 days from the date of the original remittance advice to submit corrected claims.  
Non-participating providers have 365 days from the date of service to submit corrected claims.

Original Claim Number (from Remittance Advice, if any): \_\_\_\_\_

### Provider Office Contact Information

Contact Name: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date Completed: \_\_\_\_\_ Other Information: \_\_\_\_\_

### This claim is a corrected billing of a previously processed claim for the following reason(s):

- |  |   |
|--|---|
| <input type="checkbox"/> Corrected Diagnosis           | <input type="checkbox"/> Corrected Procedure Code (CPT/HCPCS) |
| <input type="checkbox"/> Corrected Date of Service     | <input type="checkbox"/> Addition or Correction of Modifier   |
| <input type="checkbox"/> Corrected Charges             | <input type="checkbox"/> Corrected Provider Information       |
| <input type="checkbox"/> Corrected Patient Information | <input type="checkbox"/> Corrected Last Menstrual Period Date |
| <input type="checkbox"/> Corrected EPSDT Indicator     | <input type="checkbox"/> Other: _____                         |

Any specific clarification/comment/instructions (e.g., the claim line that was corrected):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supporting Documentation Attached?  Yes  No

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