



CORRECTED CLAIM – Standard Cover Sheet

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

Be sure to attach the updated claim form!

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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