PH Tech will not be able to accept requests submitted by providers to change required data elements to a claim via email, either directly to PH Tech staff or via CIM link, in order to obtain payment for that claim. Instead, providers will be required to submit a corrected claim reflecting needed changes either by paper or electronically as applicable.

*When submitting a corrected claim, you will need to re-submit the ENTIRE claim with any necessary corrections. If you submit only the corrected data and not the entire claim, your claim may not be processed correctly.*

Corrected claims MUST be submitted to PH Tech within 365 calendar days of the original adjudication date.

**Corrected Paper Claims**

1. Do not over-write or hand write changes to the original claim as these *will not be accepted.*
2. Create a new claim with applicable changes, noting in the top margin that the claim is a corrected claim
   a. Regarding bill type and box 22:
      - In many situations the 4th digit of the bill type represents the frequency of bill.
      - For inpatient, outpatient and SNF fourth digit = 0, 1, 2, 3, 4, 7, 8 (frequency of bill) Home health the fourth digit = 2, 7, 8, 9 (frequency of bill)
        0 = Nonpayment/Zero Claim
        1 = Admit-through-discharge claim
        2 = Interim – First claim
        3 = Interim – Continuing Claim
        4 = Interim – Last Claim
        7 = Replacement of Prior Claim
        8 = Void/Cancel of a Prior Claim
        9 = Final Claim for a Home Health PPS Episode
      - For professional claims the industry standard is to have the frequency code left justified in box 22.
3. Submit the paper claim as you would a new claim.
Corrected Electronic Claims

1. If submitting a corrected claim through electronic billing, the following loop information should be referenced:
   
a. Loop 2300 Claim Information
   
   - Segment CLM05-03 Claim Frequency Type Code - inserting a value of ‘7’ indicates that the claim is a replacement of the original (Facility Claims Only)
   - Segment REF-Payer Claim Control Number (these two segments correspond to CMS 1500 form, box 22a and 22b)
     REF01 – Reference Identification Qualifier, inserting a value of ‘F8’ indicates Original Reference Number
     REF02 – Reference Identification or Payer Claim Control Number, the original claim number should be listed