Submitting a Corrected Claim

GOBHI will not be able to accept requests submitted by providers to change required data elements to a claim via email, either directly to GOBHI staff or via the Provider Portal, 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 GOBHI 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 (UB04) and box 22 (HCFA 1500)
   - 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)
   - For professional claims, the industry standard is to have the frequency code justified in box 22.
   - Next to box 22, under Original Ref No. please include the original claim number.

     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

3. Submit the paper claim as you would a new claim.