[Sender Name]
[Facility/Provider Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

[Payer Name]
[Claims Department Address]
[City, State, Zip Code]

Subject: Corrected Claim Resubmission - Incorrect Patient Demographics

To Whom It May Concern,

Please find the enclosed corrected claim for the patient listed below. This claim is being resubmitted to correct previous demographic errors that resulted in a denial or rejection.

Claim Details:

- **Patient Name:** [Correct Patient Name]
- **Patient Date of Birth:** [Correct Date of Birth]
- **Subscriber ID/Policy Number:** [Member ID Number]
- **Claim Number (TCN/ICN):** [Original Claim Number]
- **Date of Service:** [Date of Service]
- **Total Billed Amount:** $[Amount]

Description of Correction:

The original claim was submitted with incorrect [Name/Date of Birth/Gender/Address]. We have updated the patient record to reflect the accurate information as provided on the patient's insurance card/legal documentation. All other billing information remains the same.

Please process this corrected claim and remit payment to the address on file. If you require additional information, please contact our billing office at [Phone Number].

Sincerely,

[Signature]
[Printed Name]
[Title/Billing Department]

Enclosures: Corrected CMS-1500/UB-04 Form, Copy of Original Denial (if applicable).