

[Your Name/Practice Name]  
[Your Address]  
[City, State, Zip Code]  
[Phone Number]  
[Date]

[Insurance Company Name]  
[Claims Department Address]  
[City, State, Zip Code]

**RE: Corrected Claim Resubmission**

**Patient Name:** [Patient First and Last Name]  
**Patient Date of Birth:** [MM/DD/YYYY]  
**Member ID Number:** [Policy ID Number]  
**Claim Number:** [Original Claim Number]  
**Date of Service:** [Date of Treatment]

To Whom It May Concern,

This letter is to formally resubmit the above-referenced claim which was previously denied or processed incorrectly due to a coding error. We have reviewed the medical documentation and updated the claim with the correct coding information as follows:

**Original Coding:** [Insert Incorrect CPT/ICD-10 Code]  
**Corrected Coding:** [Insert Correct CPT/ICD-10 Code]

**Reason for Correction:** [Briefly state reason, e.g., Clerical error, more specific diagnosis code required, or modifier addition].

Attached you will find the corrected claim form (HCFA 1500 / UB-04) and the supporting clinical documentation for your review. We kindly request that you reprocess this claim for payment based on the corrected information provided.

Please contact our billing department at [Phone Number] if you require further clarification.

Sincerely,

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

Enclosures: Corrected Claim Form, Medical Records