

Date: [Insert Date]
To: [Insurance Company Name]
Attn: Claims/Appeals Department
Address: [Insert Address]
City, State, Zip: [Insert City, State, Zip]

RE: Corrected Claim Resubmission - Modifier Adjustment

Patient Name: [Patient Name]
Patient Date of Birth: [DOB]
Member ID Number: [Member ID]
Claim Number: [Original Claim Number]
Date of Service: [Date of Service]
Billed Amount: [Total Billed Amount]

Dear Claims Department,

Please accept this correspondence as a formal resubmission of the above-referenced claim. The original claim was denied or processed incorrectly due to missing or incorrect modifiers.

We have updated the claim to include the following modifier adjustments:

- CPT/HCPCS Code: [Insert Code] - Modifier Added/Corrected: [Insert Modifier]
- CPT/HCPCS Code: [Insert Code] - Modifier Added/Corrected: [Insert Modifier]

The addition of these modifiers accurately reflects the services provided and clarifies the relationship between the procedures performed. Attached, please find the corrected CMS-1500 form along with the supporting medical documentation for your review.

We request that you reprocess this claim for payment. If you require further information, please contact our billing office at [Phone Number] or [Email Address].

Sincerely,

[Your Name/Provider Name]
[Practice Name]
[Tax ID/NPI Number]

Enclosures:

- Corrected Claim Form (CMS-1500)
- Medical Records/Operative Report
- Original Remittance Advice