

[Your Name/Organization 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 Full Name]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Claim Number: [Original Claim Number]
Original Date of Service Submitted: [Incorrect Date]
Correct Date of Service: [Correct Date]

To Whom It May Concern,

This letter is to formally resubmit the above-referenced claim as a **CORRECTED CLAIM**. The original claim was submitted with an incorrect date of service.

Please update your records to reflect the correct date of service: **[Correct Date]**. All other billing information, including procedure codes and diagnosis codes, remains the same.

Attached you will find the corrected CMS-1500/UB-04 form and any supporting clinical documentation. Please process this claim for payment at your earliest convenience.

Thank you for your assistance. If you require further information, please contact me at [Your Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Office Name]

Enclosures: Corrected Claim Form, [Additional Documents]