

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

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

RE: Corrected Claim Resubmission - Provider Identification Error

To the Claims Department,

This letter is to formally resubmit the following claim which was previously denied due to a provider identification error (e.g., incorrect NPI, Tax ID, or Provider Name).

Claim Details:

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Member ID Number: [Member ID]
Original Claim Number: [Original Claim ID/Reference Number]
Date of Service: [Date of Service]
Total Billed Amount: \$[Amount]

Correction Details:

The original claim contained an error regarding: [Specify error, e.g., Rendering Provider NPI].
The corrected information is: [Insert Correct Identification Information].

Please find the corrected claim form attached for reprocessing. We request that the original denial be overturned and the claim be adjudicated based on the updated provider information provided.

If you require further documentation, please contact our billing department at [Your Phone Number] or [Your Email Address].

Sincerely,

[Your Name/Signature]
[Your Title]
[Practice/Facility Name]

Enclosures:

- Corrected Claim Form (CMS-1500 or UB-04)
- Original Remittance Advice/Denial Letter