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

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

RE: Corrected Claim Resubmission with Updated Prior Authorization

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

To Whom It May Concern,

This letter is to formally resubmit the above-referenced claim as a **CORRECTED CLAIM**. The original submission was denied or processed incorrectly due to missing or outdated authorization information.

We have updated the claim to include the following Prior Authorization details:

- **Prior Authorization Number:** [Authorization Number]
- **Effective Dates:** [Start Date] to [End Date]
- **Approved Units/Services:** [Description of Services]

Please find the attached corrected CMS-1500/UB-04 form and a copy of the authorization approval letter. We request that you reprocess this claim for payment based on this updated information.

If you require any additional documentation, please contact our billing department at [Phone Number]. Thank you for your prompt attention to this matter.

Sincerely,

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

Enclosures:
- Corrected Claim Form

- Prior Authorization Approval Letter
- Original Explanation of Benefits (EOB)