[Sender Name]
[Facility/Practice Name]
[Address]
[Phone Number]
[Date]

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

RE: Corrected Claim Resubmission - Coordination of Benefits (COB)

Patient Name: [Patient Name]
Member ID: [Member ID Number]
Group Number: [Group Number]
Claim Number: [Original Claim Number]
Date of Service: [Date of Service]
Billed Amount: $[Amount]

To Whom It May Concern,

This letter is to formally resubmit the above-referenced claim as a **Corrected Claim**. The initial claim was denied or processed incorrectly due to missing or updated Coordination of Benefits (COB) information.

We have enclosed the following documentation to facilitate proper processing:

- A copy of the Primary Explanation of Benefits (EOB) from [Primary Insurance Name].
- The corrected CMS-1500/UB-04 form reflecting primary payment information.
- [Optional: A copy of the patient's secondary insurance card].

Please update the patient's COB profile and process this claim for the remaining balance according to the member's secondary coverage benefits.

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

Sincerely,

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