Date: [Date]

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

RE: Corrected Claim Resubmission
Patient Name: [Patient Full Name]
Patient Date of Birth: [DOB]
Member ID Number: [Member ID]
Claim Number: [Original Claim Number]
Date of Service: [Date of Service]

Dear Claims Reviewer,

This letter is to formally submit a corrected claim for the date of service listed above. The original claim was denied or processed incorrectly due to a diagnosis code error.

Upon internal review, it was determined that the diagnosis code(s) required revision to accurately reflect the patient's condition and the medical necessity of the services provided.

Revisions Made:

- Original Diagnosis Code(s): [Original Code(s)]
- Corrected Diagnosis Code(s): [New Code(s)]

Please find the corrected HCFA-1500/UB-04 form attached, clearly marked as a "Corrected Claim." We have also included relevant medical documentation to support the updated diagnosis.

We request that you reprocess this claim with the corrected information. If you require any additional information, please contact our office at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name/Signature]
[Practice/Facility Name]
[Tax ID Number/NPI Number]