

[Your Name/Practice Name]

[Your Address]

[City, State, Zip Code]

[Phone Number]

[Tax ID / NPI Number]

[Date]

[Insurance Company Name]

[Claims Department Address]

[City, State, Zip Code]

RE: Corrected Claim - Billed Amount Adjustment

Patient Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [Insurance ID Number]

Claim Number: [Original Claim Number]

Date of Service: [Date of Service]

To Whom It May Concern,

This letter is to formally submit a corrected claim for the above-referenced patient. We are resubmitting this claim specifically to adjust the billed amount for the services provided.

The original claim submitted on [Original Submission Date] contained an incorrect total billed amount of \$[Original Amount]. The corrected and accurate billed amount for this date of service is \$[Corrected Amount].

Please find the following documents enclosed to facilitate the reprocessing of this claim:

- Corrected CMS-1500 / UB-04 Form (marked "Corrected Claim")
- Original Explanation of Benefits (EOB), if applicable
- Supporting medical documentation (if required)

We request that you void the previous submission and process this corrected claim for payment based on the adjusted amount. Please update your records to reflect this change.

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

Sincerely,

[Signature]

[Printed Name]

[Title/Billing Department]