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

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

RE: Corrected Claim Resubmission - Invalid Place of Service

Patient Name: [Patient Name]
Member ID: [Member ID 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 original claim was denied or returned due to an "Invalid Place of Service" (POS) code.

We have updated the Place of Service code to **[Insert Correct POS Code, e.g., 11 for Office]** to accurately reflect the location where services were rendered. No other changes have been made to the clinical coding or billed amounts.

Please find the corrected HCFA-1500 form attached. We request that you reprocess this claim for payment at your earliest convenience.

If you require any additional information, please contact our billing department at [Phone Number].

Sincerely,

[Signature]
[Printed Name]
[Title]

Enclosure: Corrected Claim Form