ARISE CORRECTED CLAIMS

This form must be completed and attached to your corrected claim. **Requests submitted without a completed form will be returned**. You must identify the information being changed or corrected, explain why the change or correction is being requested and provide supporting documentation as necessary.

Provider Name:	Date Prepared:
Contact Name:	Phone Number:

Member Name:	Member Number:
Date of Service:	Original Claim Number:

Reason(s) for Corrected Claim:
(Please check appropriate box(es))

- ☐ Corrected diagnosis
- ☐ Corrected date of service
- ☐ Corrected charges
- ☐ Corrected patient information
- ☐ Corrected billing code (HCPC, CPT, Revenue Code or DRG)
- ☐ Addition, or correction, of modifier
- ☐ Corrected provider information
- ☐ Other:_____

For each box checked above, please be specific about the correction that was made and justification:

_____

_____

_____

_____

_____

☐ Supporting documentation attached.

Please mail completed form along with corrected claim and supporting documentation, as applicable, to the below address.

New address for paper claim submissions
If you previously submitted claims to P.O. Box 981641, El Paso, TX, please use the address below, effective Aug.1, 2016, for all paper claims and claim-related correspondence.

Arise Health Plan
P.O. Box 21352
Eagan, MN 55121

Arise HEALTH PLAN
Choose It and Use It.