



# Corrected Claim Submission Form



**Do not use this form to re-submit a claim that was previously denied.  
Use of this form is not required for re-submission of a denied claim.**

## Instructions

Use this form to submit a corrected, previously paid claim. See your Alliance Provider Manual and/or Alliance Policy 600-1009 - Corrected Claim Submissions for more information on the submission of corrected claims.

## Part 1: Provider information

Provider Name: \_\_\_\_\_ TAX/NPI#: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Member Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

Your Name: \_\_\_\_\_

## Part 2: Claim Information

*Please provide corrections or additional information necessary to reconsider the previously paid claim.*

Claim Control Number (CCN) and Line Number(s): \_\_\_\_\_

What is being corrected? Why? Please state clearly and precisely:

## Please remember to include with this form:

- A copy of the corrected claim
- Additional information or attachments as necessary

## Return this form

Mail to:

Central California Alliance for Health, Attn: CORRECTED CLAIMS  
P.O. Box 660015, Scotts Valley, CA 95067-0015.

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