CLERICAL ERROR REOPENING REQUEST FORM

Date Submitted:	
Provider Number:	
NPI:	

Patient Name:		
Patient Medicare Number:		
Dates of Service (DOS): When changing DOS please list the original DOS.	From:	Through:
Type of Bill (TOB):		
DCN:		
Status/Location (S/LOC):		
Processed/Paid Date:		

Please explain circumstances for the reopening request:

Please attach an adjusted UB-04 with the correct data. All required fields for reopening requests MUST be completed on the UB-04 (i.e. Adjustment TOB (XX7), Cross-reference DCN, and appropriate Condition Code). Highlight all fields that are being changed/corrected. Please allow 30 days for processing.

Contact Person/Name:	
Contact Phone Number:	

NOTE: Forms that are not filled out completely will be returned unprocessed.

Please mail completed form and adjustment claim to:

CGS
J15 Part A Claims
PO Box 20211
Nashville, TN 37202

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