Anthem Blue Cross

Submitting Medicare Advantage Corrected Claims

- When submitting a corrected claim, clearly identify the claim as a correction to an original bill.

**Medical Claims**
- **Electronic CMS-1500 Claims** Enter Claim Frequency Type code (billing code) 7 for a replacement/correction, or 8 to void a prior claim, in the 2300 loop in the CLM*05 03. Enter the original claim number in the 2300 loop in the REF*F8*.
- **Paper CMS-1500 Claims**
  - Anthem will continue to accept "corrected claim" written anywhere on the face of the 1500 claim
  - Anthem will continue to accept the Anthem Provider Adjustment Request Form clearly identifying the information being corrected.
  - Anthem will accept entry in box 22 of the claim: Use Resubmission Code 7 to notify us of a corrected or replacement claim, or insert an 8 to let us know you are voiding a previously submitted claim. Enter the ‘original’ claim number in the Original Ref. No. field, or if that information is not available, enter the original document control number (DCN).

- **Facility Claims UB-04 Electronic or Paper**
  - Anthem will continue to accept the Anthem Provider Adjustment Request Form clearly identifying the information being corrected.
  - When submitting a corrected claim ensure the type of bill is xx7 (correction/replacement) or xx8 (void) when the correction is within the initial claim 1 year timely filing limitation.

When the need for a claim correction is identified and the claim is beyond the timely filing limit of 1 calendar year from the "through" date on claim, a reopening request type of bill XXQ should be submitted to remedy the error. Reopenings are typically used to correct claims with clerical errors, including minor errors and omissions, and are conducted at the discretion of the plan therefore is not appealable and the original initial determination stands as a binding decision, and appeal rights are retained on the original initial determination. Omissions do not include failure to bill items/services, such as late charges. Note: there is a special congressionally mandated time frame for adjustments and reopenings that result in higher weighted DRGs. These must be filed within 60 days from the initial claim determination.