

# Claim Resubmission Request Form (commercial plans only)

**INSTRUCTIONS:**

- This form is required when submitting a claim adjustment or corrected claim in paper form.
- If the claim was previously denied, but is within the 180 day filing limit, you may resubmit electronically. Otherwise, please submit with this form.
- Be sure to use a separate form for each request.

Date Requested	<input type="text"/>	NDC# or formula HCPC, if applicable	<input type="text"/>
Claim #	<input type="text"/>	Provider Name:	<input type="text"/>
Date of Service	<input type="text"/>	Contact Name:	<input type="text"/>
Member Name	<input type="text"/>	Contact Phone:	<input type="text"/>
Member ID #	<input type="text"/>		

Did you receive any payment for the claim noted above, including any amounts for which the member is responsible (i.e., deductible)? Please select the appropriate "Yes" or "No" box below.

Yes.

Check only one (1) box below to describe the reason for your request. Attach a corrected CMS 1500/UB04 as applicable.

- |   |   |
|---|---|
| <input type="checkbox"/> Late charges               | <input type="checkbox"/> Incorrect provider                   |
| <input type="checkbox"/> Authorization(new/revised) | <input type="checkbox"/> Incorrect procedure code             |
| <input type="checkbox"/> Modifier (added/multiple)  | <input type="checkbox"/> Incorrect amount billed              |
| <input type="checkbox"/> Incorrect date of service  | <input type="checkbox"/> Other - please explain; be specific: |

No.

Check only one (1) box below to best describe the reason for your request. A corrected CMS 1500/UB04 must be attached in order to process your request.

- |   |   |
|---|---|
| <input type="checkbox"/> Corrected location                       | <input type="checkbox"/> Added/revised 1st modifier |
| <input type="checkbox"/> Resubmitted with primary carrier EOP/EOB | <input type="checkbox"/> Added/revised 2nd modifier |
| <input type="checkbox"/> Other - please explain; be specific:     |   |

Send to: ConnectiCare  
 Attn: Claims - Resubmission Request  
 P.O. Box 546  
 Farmington, CT 06034-0546