Corrected Claims Billing Requirements

Providers can submit corrected claims when changing or adding information, such as a change in coding. There are two ways to submit a corrected claim to Molina Healthcare:

1. Electronic Data Interchange (EDI)
2. Molina Healthcare's Provider Portal

When submitting corrected claims to Molina Healthcare, follow these billing requirements:

- **Always** submit through the Provider Portal or EDI, payer ID: 20149, as indicated in the steps below
- **Do not** submit corrected claims through the claims reconsideration process
- **Always** include the original claim in its entirety with the corrections made
- **Do not** submit a corrected claim with only codes that were edited by Molina Healthcare on the original claim

Provider Portal Submission

- Log in with your username and password
- Select "Create a professional claim" from the left menu
- Select the radio button for the correct claim option
- Enter the ID number of the claim you want to correct
- Make corrections and add supporting documents explanation of benefits (EOB)
- Submit your claim

Electronic Submission

CMS 1500

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
  - "7" – REPLACEMENT (replacement of prior claim)
  - "8" – VOID (void/cancel of prior claim)
- The 2300 Loop, the REF segment (claim information), must include the original claim number of the claim being corrected, found on the remittance advice

UB04

- Bill type for UB claims are billed in loop 2300/CLM05-1
  - In Bill Type for UB, the 7 or 8 goes in the third digit for "frequency"
- The 2300 Loop, the REF segment (claim information), must include the original claim number of the claim being corrected, found on the remittance advice

Corrected Claims Billing Requirements

Timely Filing

Par Providers

- Claims received with a correction of a previously adjudicated claim must be received by Molina Healthcare no later than the filing limitation stated in the provider contract or within 365 days of the original remittance advice
- Claims submitted after the filing limit will be denied

Non-Par Providers

- Non-participating providers have 365 days of the original remittance advice to submit corrected claims

Additional Information

To learn more, see our Claim Submission Training Guide under the "Manual" tab at www.MolinaHealthcare.com/OhioProviders.

You can also call Provider Services at (855) 322-4079 Monday through Friday from 8 a.m. to 6 p.m. for MyCare Ohio, and 8 a.m. to 5 p.m. for all other lines of business.