MACSIS CLAIMS CORRECTION FORM

For reporting erroneous claims

Sending Organization Name:______________________________
Receiving Organization Name:____________________________
Provider MACSIS Unique Provider Identifier (UPI): __________
Date Received: ______________
Date Completed:_____________

Person Reporting Errors: ______________________
Phone Number: ____________________________
Return Form to Attn: __________________________
Errors Apply to Fiscal Year: ____________________

	UCI #	DOS	MACSIS Claim #	Billed Amount	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Units	POS	COB Amt	Cob Ind[1]	Prov Pt Ctrl #
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment [2]:														
Board Action/Response:												*Date:*		*Initials:*
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment [2]:														
Board Action/Response:												*Date:*		*Initials:*
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment [2]:														
Board Action/Response:												*Date:*		*Initials:*
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment [2]:														
Board Action/Response:												*Date:*		*Initials:*

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[1] Must use one of the allowable ODJFS COB Indicator values: 2-6, R, P, F, L S, E, X

[2] Denote reason for error: wrong patient, date of service, units, procedure, modifier, 3rd party pmt/indicator, etc. or MACSIS Reason Code

Provider Representative Signature (required): ______________________________ Date (required): ___________

If submitting via electronic media, type name above; add electronic signature: (check box) ☐