Prestige
HEALTH CHOICE®
Leading the Way to Quality Care

April 2018

Corrected Claim – Discontinue Use of Frequency Code 6

Summary: Effective immediately**, please discontinue use of frequency code "6"** when submitting a corrected claim. Please see requirements below for the submission of corrected/replacement and voided claims.

Corrected/replacement and voided claims may be sent electronically or on paper.

- If sent electronically, the ***claim frequency code*** (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values '**7**' for the Replacement (correction) of a prior claim or '**8**' for the Void of a prior claim. The value '**6**' should no longer be used.
- In addition, you must also provide the original claim number in ***Payer Claim Control Number*** (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files). This is not a unique requirement of the Plan but rather a requirement of the mandated *HIPAA Version 5010 Implementation Guide*.
- If the corrected claim is submitted on paper, the claim must have the following in order to be processed:
    - On a Professional CMS 1500 Claim, the resubmission code of "7" or "8" and the Plan's original claim number must be in Field 22.
    - On an Institutional UB04 Claim, bill type should end in "7" or "8" in Form Locator 4 and the Plan's original claim number must be in Form Locator 64A Document Control Number.

Reminders:

- You may only resubmit as a corrected or replacement claim when you have received an original Prestige Health Choice claim number.
- Do not utilize the corrected claim process if the claim was rejected by Prestige (does not appear on a Remittance Advice)

Questions:

If you have questions about this communication, please contact your Provider Account Executive or the Provider Services department at **1-800-617-5727.**

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