CenCal HEALTH™
The Regional Health Authority

CLAIM CORRECTION FORM - Non-Claim Mail (NCM)

CenCal Health's Claims Department is working at ways to assist you with correcting your claim(s) and obtaining payment in the most efficient way possible. To expedite the adjudication of your corrections, please provide us with the requested information below.

Please note: If your claim was denied for a signature or consent form, you must provide a hardcopy claim, with appropriate corrections along with this form.

* *REQUIRED FIELDS*

*Claim Control Number (CCN):	Member's Last Name:
*Plan ID: ☐SBHI ☐SLOHI ☐PP2 ☐SBHK ☐SLOHK ☐IHSS	* NPI:
Provider Name:	Name of person submitting corrections:
Provider Address (*NCM Return Address):*	
Provider Type: ☐ Physician ☐ Inpatient Hospital ☐ Outpatient Hospital ☐ LTC ☐ Vision ☐ DME – Type________________________ ☐ Other ______________________________	
Relationship to Provider: ☐ Self ☐ Office Staff ☐Billing Service ☐Other______________	
* Description of requested correction (*please indicate specific line #'s, if applicable, and/or attach additional pages as needed and include all available supporting documentation)*:	

PLEASE RETURN THIS FORM AND ANY ATTACHMENTS TO THE ADDRESS BELOW:

110 Castilian Dr. ◾ Goleta, CA 93117-3028 ◾ Attention: Adjudication Department