



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:
*Member’s Plan ID: <input type="checkbox"/> SBHI <input type="checkbox"/> SLOHI <input type="checkbox"/> PP2 <input type="checkbox"/> HFP <input type="checkbox"/> SBHK <input type="checkbox"/> SLOHK <input type="checkbox"/> IHSS		* NPI:
Provider Name:		Name of person submitting corrections:
Provider Address (NCM Return Address):		
Provider Type: <input type="checkbox"/> Physician <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> LTC <input type="checkbox"/> Vision <input type="checkbox"/> DME – Type _____ <input type="checkbox"/> Other _____		
Relationship to Provider: <input type="checkbox"/> Self <input type="checkbox"/> Office Staff <input type="checkbox"/> Billing Service <input type="checkbox"/> Other _____		
* Description of requested correction (<i>please indicate specific line #'s, if applicable, and/or attach additional pages as needed and include all available supporting documentation</i>):		

PLEASE RETURN THIS FORM AND ANY ATTACHMENTS TO THE ADDRESS BELOW:
4050 Calle Real • Santa Barbara, CA 93110 • Attention: Adjudication Department