Health First
Health Plans

PROVIDER CORRECTED CLAIM FORM MODIFIER 25/59

INSTRUCTIONS:

- This form must be returned within **6 months** from the date of service.
- Use one form for each corrected claim containing the addition of the modifier.
- Provide all supporting documentation for the addition of the modifier.
- Please allow 30 days to elapse before checking the status of your dispute.
- Mail or fax this form to: Health First Health Plans, Medical Expense Team, 6450 US Highway 1, Rockledge, FL 32955 — Fax: (321) 434-5655
- Health First Health Plans will resolve your dispute within **60 days** of receiving this form.
- If the reconsidered decision is in your favor, you will receive a corrected payment and a new Remittance Advice. If the decision is not in your favor, you will receive a letter explaining the reason for the decision.
- **Note**: According to Florida Statutes (FS 641.3154) you may not balance bill members of Health First Health Plans during this process.

PROVIDER INFORMATION

Provider Name:	Contact Person:
Provider Billing Address:	
Phone Number:	Fax Number:

PATIENT INFORMATION

Patient Name:	Patient ID#:	Patient Date of Birth:	Plan Type (i.e. Medicare, Commercial, TPA)

CLAIM INFORMATION

Date of Service:	Amount Billed:	Amount Paid:	Claim# and Line Item:

DISPUTE INFORMATION

Describe the desired outcome and why you feel it is appropriate. Attach supporting documentation.

Authorized Representative Name (please print) Title

Authorized Signature Date

Health Plan use only: