Date of Service Claim Correction Form –

In order to correct previously submitted claim(s) that were submitted/processed with incorrect Dates of Service, please provide CenCal's Claims department with the requested information below.

* ***REQUIRED FIELDS***

*Claim Control Number (CCN):	Member's Last Name:
*Member's Plan ID: ☐SBHI ☐SLOHI ☐AIM ☐SBHK	* NPI:
Provider Name:	Name of Provider Representative:
Provider Address (*Return Address):*	
Provider Type: ☐ Physician ☐ Inpatient Hospital ☐ Outpatient Hospital ☐ LTC ☐ Vision ☐ DME – Type_____ ☐ Other _____	
Relationship to Provider: ☐ Self ☐ Office Staff ☐Billing Service ☐Other_____	
Change Date of Service from_____to _____	
* *Comments/Remarks*	

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

4050 Calle Real, Santa Barbara, CA 93110
Attention: Claims Department
Fax: 805.681.8261

Revised 03/23/2015