

PROVIDER UPDATE

Resubmitting a Claim with a New EOB

When resubmitting a claim with a new EOB, it must be submitted with resubmission indicators. Below is the information on how to do this for paper and electronic for both facility and professional.

Paper Claims

Professional Claims: Box 22 should be submitted with the appropriate resubmission code with the original claim number of the corrected claim.

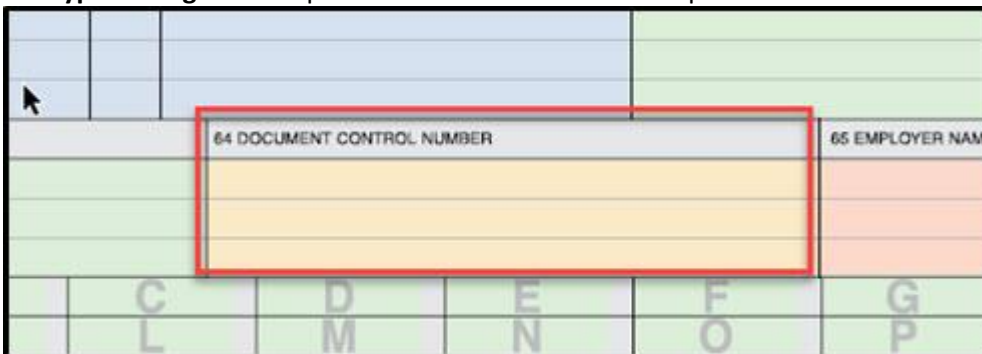
Resubmission Code 7 - Replacement or resubmission of a prior claim.



The image shows a portion of a claim form. A red rectangular box highlights the field labeled "22. RESUBMISSION CODE" which contains the number "7". Other visible fields include "15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION", "18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES", "20. OUTSIDE LAB?", and "23. PRIOR AUTHORIZATION NUMBER AUTH N/A".

Facility claims: Box 4 should be submitted with the appropriate resubmission code in the third digit of the bill type and the original claim number in Box 64.

Bill Type ending in 7 – Replacement or resubmission of a prior claim.



The image shows a portion of a claim form with a grid layout. A red rectangular box highlights the field labeled "64 DOCUMENT CONTROL NUMBER". To its right is the field "65 EMPLOYER NAME". Below the grid, the letters C, D, E, F, G are visible above L, M, N, O, P.

Electronic Claims

Professional claims: The resubmission code is the Freq Type Cd as seen in the image below. If a claim is a resubmission, the code will be a 7 (see below for code descriptions) and the original claim number will be in the highlighted area below.

Resubmission Code 7 - Replacement or resubmission of a prior claim.

2300 CLAIM LEVEL INFORMATION LOOP:
PATIENT ACCOUNT NER: [REDACTED]
FREQ TYPE CD: 1 MEDICARE ASG CD: A BENE
ACCIDENT/EMPL RELATED CAUSE CD: ACC

ONSET OF ILLNESS DT: INITIAL
LAST MENSTRAL PD DT: HEAR/VISION
DISABII
ADMISSION DT: DISAB
DISCHARGE DT: DISAB

DIAGNOSIS QUALIFIERS AND CODES (CAN OCCUR U
ABK M9903 ABF M5441 ABF M9903

ANESTHESIA SURG PROC CD: ANESTHES

CONDITION CODES (CAN OCCUR UP TO 24 TIMES)

PATIENT AMT PAID QUAL: PATIENT AMT PAID

REFERRAL NO:
~~ORIG AUTH NO:~~
ORIG CLAIM NO: [REDACTED]

Facility claims: On the Claim Level Information Loop page, the appropriate resubmission code will be the third digit of the bill type. If a claim is a resubmission, the last digit will be a 7 and the original claim number will be in the highlighted area below.

Bill Type ending in 7 – Replacement or resubmission of a prior claim.

2300 CLAIM LEVEL INFORMATION LOOP:
PATIENT ACCOUNT NER: [REDACTED] CLAIM TOTAL CHARGE: 8588.49 TYPE OF BILL: 111
MEDICARE ASG CD: A BENEFITS ASG CD: Y RELEASE INFO CD: Y DELAY REASON CD:

DISCHARGE HOUR: 14 ADMISSION DT: [REDACTED] ADMISSION TYPE CD: 2
STATEMENT BEGIN DT: [REDACTED] ADMISSION HR: 23 ADMISSION SOURCE CD: 1
STATEMENT END DT: [REDACTED] ADMISSION MIN: 00 PATIENT STATUS CD: 01

PRINCIPAL DIAGNOSIS QUAL: [REDACTED] CD: [REDACTED] POA: Y REPRIGER RECEIPT DT:
ADMITTING DIAGNOSIS QUAL: [REDACTED] CD: [REDACTED]
REASON FOR VISIT NONE

EXTERNAL CAUSE OF INJURY (QUAL, CODE, POA. CAN OCCUR UP TO 12 TIMES):

OTHER DIAGNOSIS INFO (QUAL, CODE, POA. CAN OCCUR UP TO 24 TIMES):
ABF [REDACTED] N ABF [REDACTED] ABF [REDACTED]

PRINCIPAL PROCEDURE QUAL: [REDACTED] CD: [REDACTED] DATE: [REDACTED] DRG CODE: [REDACTED]
OTHER PROCEDURE INFO (QUAL, CODE, DATE. CAN OCCUR UP TO 24 TIMES):

REFERRAL NO:
~~ORIG AUTH NO:~~
ORIG CLAIM NO: [REDACTED] CLEARINGHOUSE TRACE NO: [REDACTED]