



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION



### Reopening: Simple Claim Correction

**ALL fields are REQUIRED.**

#### Provider Information

#### Requestor Information (if different)

#### Patient & Claim Information

Provider Name:

Requestor Name:

Patient Name:

Provider Address:

Requestor Address:

Medicare Number:

Provider Telephone Number:

Requestor Telephone Number:

Claim Number (ICN):

National Provider Identifier (NPI):

Claim Date(s) of Service:

Provider Number (PTAN):

CPT Codes Being Appealed:

Tax ID:

Diagnosis Code:

Reason for Reopening (What Corrections Need to be Made?):

Name (Please Print):

Signature:

Date:

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**PLEASE ATTACH:**

1. Please attach this form completed in its entirety.
2. Please include Remittance Advice (RA).
3. If you have **multiple claims for the same issue**, only one form is needed provided you attach Remittance Advice (RA) forms and clearly indicate (circle or asterisk) which claims need to be changed.

AP-RRB-B-1020



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Please mail this form and all additional documentation to:

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