

CLAIM CORRECTION REQUEST
Use one (1) form per Claim Reference Number (CRN)

CRN:	
Provider Name:	Provider AHCCCS ID:
Contact:	Today's Date:
Member's Name:	Member's AHCCCS ID:
DOS:	Original Billed Amount:

Please complete the section below with the corrections needed to reprocess your claim:

Claim Line #	DOS	Service Code	Modifier	Diagnosis	Units	Charges

Comments or Questions:

To contact the Capstone Claims Department: Phone: (928) 779-2113
Toll Free: (800) 336-3874
Fax: (928) 779-5108
E-mail: claims@nazcap.com

This form may be used to resubmitt claims that have been previously denied, reversed or not paid as expected due to innaccurate or ommitted information on the original claim submission. It is not to be used for hospital resubmissions or claims requiring additional information such as EPSDT forms, Medical Records, EOB's, etc.