



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

INCOMPLETE FORMS WILL BE RETURNED

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

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

Claim Line #	Date of Service		CPT/HCPC		Diagnosis	Units	Charges
	From	To	Service Code	Modifier			

Comments or Questions:

Please sign and date:

To contact the Capstone Claims Department: Phone: (928) 214-3483 or 214-3493
 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.

This form will not to be accepted for hospital resubmissions or claims requiring additional information such as EPSDT forms, Medical Records, EOB's, etc.