IRIS PAID CLAIM ERROR FORM

BERRIEN MENTAL HEALTH AUTHORITY / RIVERWOOD CENTER

Date: _____ Name/Title of Requestor: _____

IMPORTANT: If an error has been made on a claim which has already been paid, BMHA will void the claim and recoup the payment. If there is a correction to be made, enter a new corrected claim and include the new claim information to ensure correct payment or recoupment of the claim. A new claim MUST be entered for Payment to be made.

**Billed rate issues do not need this form. Contact Claims Specialist.

Provider :

Consumer: **Case #:**

Paid Claim:		Corrected Claim:	
Paid Batch #		Corrected Batch #	
Paid Claim #		Corrected Claim #	
Date(s) of Service		Date(s) of Service	
Code/Modifier		Code/Modifier	
Units		Units	
Charge		Charge	
*Start Time		*Start Time	
*Stop Time		*Stop Time	

*If Required *If Required

Comments:

Signature:

Riverwood Reconsiderations:

Date Received: _____

Date Voided: _____

Approval Signature: _____

Please Fax Form to 269-934-3388 or email amy.groom@riverwoodcenter.org