Submitting corrected claims electronically

Guidelines for professional and institutional ANSI-837 claims

Share with your vendor

Providers are encouraged to share the following guidelines with their electronic vendor to assist in the submission of corrected claims in the ANSI-837 professional and institutional electronic formats to Anthem Blue Cross and Blue Shield Medicaid.

ANSI-837P: professional claims

Both items listed below must be completed for an ANSI-837 professional claim to be considered a corrected claim:

1. In the **2300 Loop**: under the claim information (CLM) segment, **CLM05-3** (claim frequency type code) must indicate one of the following qualifier codes:
   - ☐ 7 – REPLACEMENT (replacement of prior claim)
   - ☐ 8 – VOID (void/cancel of prior claim)
2. In the **2300 Loop**: the original reference number (ICN/DCN) (**REF02**) segment must include the original claim number issued to the claim being corrected. The original claim number can be found on your remittance advice.

ANSI-837I: institutional claims

Both items listed below must be completed for an ANSI-837 institutional claim to be considered a corrected claim:

1. In the **2300 Loop**: under the claim information (CLM) segment, the **CLM05-3** (claim frequency type code) must indicate the third digit of the type of bill being sent. The third digit of the type of bill is the frequency and can indicate if the bill is an adjustment, replacement or voided claim as follows:
   - ☐ 7 – REPLACEMENT (replacement of prior claim)
   - ☐ 8 – VOID (void/cancel of prior claim)
2. In the **2300 Loop**: the original reference number (ICN/DCN) (**REF02**) segment must include the original claim number issued to the claim being corrected. The original claim number can be found on your remittance advice.

Questions?

For technical support assistance contact E-Solutions at **1-800-470-9630** Monday through Friday from 8 a.m. to 4:30 p.m. Eastern time, or via email at **e-solutions.support@anthem.com**.

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