



## Corrective Action for Denied Paper Claims

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Claims will be processed at the header level in NewMMIS. This means that if you submit a claim with multiple detail lines, all lines will stay together as one claim during processing and will be assigned one internal control number (ICN) that will be the claim identifier.

Follow the appropriate corrective action for a denied claim. **Note:** Dental providers should consult their MassHealth provider manual or contact the MassHealth Dental Third-Party Administrator at 1-800-207-5019.

### Original Claim Was Submitted Within 90 Days

If the resubmitted claim will be received by MassHealth within 90 days of the date of service, you may correct all errors using the following method.

- If you are within 90 days of the dates of service on the denied claim lines, you can send in a new claim with only the corrected denied lines, and attach any required documentation. A former ICN is not required.
- Submit the claim to:  
MassHealth  
P.O. Box 9118  
Hingham, MA 02043

If the resubmitted claim will be received by MassHealth over 90 days, but within 1 year, of the date of service, you may correct all errors using the following method.

- Prepare a new claim form, including both paid and denied lines as they appeared on the original claim submission, with the corrected information, and attach any required documentation. Failure to submit all claim lines in this instance will result in the void of previously paid omitted lines.
- A former ICN is not required if your claim meets the following criteria:
  - the original claim was submitted within the 90-day period and appeared as denied on the remittance advice; and
  - the member ID number, pay-to-provider number, revenue code, service code, claim type, and service date are not changing.
- Submit the claim to:  
MassHealth  
P.O. Box 9118  
Hingham, MA 02043

Use the former ICN to resubmit the claim if one or more of the following items are changing and submit all claim lines as they appeared on the original claim service date, revenue code, or service code.

- Submit the claim to:  
MassHealth  
Attn: Resubmittals  
P.O. Box 9118  
Hingham, MA 02043

## Corrective Action for Denied Paper Claims (cont.)

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If you are making changes to the member ID number or pay-to-provider number/claim type, the former ICN cannot be used. You must request a 90-day waiver and include a cover letter and supporting documentation. Use the following method to request a waiver.

- Prepare a corrected claim form. Multiple claim lines can be submitted on a single claim form.
- Attach a cover letter with any documentation that was included with your original submission and additional supporting documentation, such as a copy of the remittance advice showing that your original claim was received within 90 days.
- Attach the 90-day waiver request form to each claim stating the reason for the waiver request.
- Do not enter resubmittal or adjustment information and do not enter a former ICN.
- Submit the claim to:  
MassHealth  
Attention: 90-Day Waivers  
P.O. Box 9118  
Hingham, MA 02043

### Original Claims Submitted Over 90 days

If the original claim was denied because it was submitted 90 days from the date of service, and the claim meets the criteria outlined in MassHealth regulations at 130 CMR 450.309 through 450.314, you must submit a 90-day waiver request with a cover letter and the supporting documentation.

Use the following method to request a waiver.

- Prepare a new paper claim form.
- Attach to each claim a copy of all Remittance Advices where the claim has appeared, if applicable.
- Attach to each claim any other supporting documentation, such as copies of retroactive enrollment notices.
- Attach the 90-day waiver request form to each claim stating the reason for the waiver request.
- Do not enter resubmittal or adjustment information and do not enter a former ICN.
- Submit the claim to:  
MassHealth  
Attention: 90-Day Waivers  
P.O. Box 9118  
Hingham, MA 02043

The following circumstances do **not** require a 90-day waiver:

- claims that will be received within 90 days from the date on a third-party payer's EOB and still within 18 months of the service date; and
- claims that can be resubmitted according to the instructions in this document.