



Child Health Administrative Services

Claim Edit Request Form (NextGen EPM Only)

Fax To: (513) 636-5254 Attention: Application Specialist Team

From: _____

Practice Name: _____

Today's Date: _____

Phone: _____

Practice Fax: _____

Please complete all applicable information.

CPT Code	Diagnosis Code	Purpose of Edit	Specific Insurance Company or All	*Requested as "REQUIRED" <input type="checkbox"/>	**Requested as "WARNING" <input type="checkbox"/>

*If the edit is set as **REQUIRED**, the claim will not be created until the correction is made.

If the edit is set as a **WARNING, the user will be **warned**, and the claim can be created even if the correction is not made.

Date Received by CHAS: _____ Date Presented to CAP: _____ Date Presented at TUG: _____ Date Completed: _____

Completed By: _____