Claim Edit Request Form
(NextGen EPM Only)

Community Practice Services

Fax To: (513) 636-0504 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" ☑	**Requested as "WARNING" ☑

*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 Community Practice Services: _____[] Date Presented to CAP: _____[] Date Presented at TUG: _____[]

[] Date Completed: _____ [] Completed By: _____