Sonoma County Behavioral Health (SCBH)
SmartCare CORRECTION FORM
For Billing Corrections

To: DHS Admin. Claiming Unit

Manager/Supervisor Approval Printed Name/ Signature: _____

From Program Name: _____ **Date:** _____

Prepared by: _____ **Phone Number:** _____

Error Types: SELECT *ONE:*

- ☐ Duplicate Service
- ☐ Incorrect Client/Number
- ☐ Incorrect Practitioner
- ☐ Incorrect Date
- ☐ Incorrect Duration (Face to Face, Non Face to Face, & Total)
- ☐ Group Correction
- ☐ Incorrect Location
- ☐ Incorrect Procedure Code
- ☐ No Progress Note
- ☐ Non-Billable Service
- ☐ Note Written to Incorrect Program
- ☐ Incorrect Client Plan Date(s)

☐ Other (Please Explain in detail) _____

Services identified and warrant some type of correction must be reported to the Revenue Management Unit (RMU) using the MHS 702 form within 60 calendar days after the date on which the error was identified.

Original Service Information:

Program Name: _____ RU #: _____

Client Name: _____ Client #: _____

Duration Face to Face: _____ Duration Non Face to Face: _____ Total Duration: _____

Written On Date:_____ Service Date: _____ Start Time: _____

Procedure: _____ Group Count: _____ Location: _____

Practitioner Name and #: _____

Co-Practitioner Name and #: _____ Duration Face to Face: _____ Non Face to Face: _____ Total $ _____

Correct Service Information:

Duration Face to Face: _____ Duration Non Face to Face: _____ Total Duration: _____

Procedure: _____ Group Count: _____ Location: _____

Practitioner Name and #: _____

Co-Practitioner Name and #: _____ Duration Face to Face: _____ Non Face to Face _____

For Claiming Use Only

Corrected By: _____ On Date: _____

Type of Correction: ☐ V&R ☐ Error ☐ Edit Claimed?: ☐ Y ☐ N