

Sonoma County Behavioral Health (SCBH)
AVATAR CORRECTION FORM

For billing Corrections

To: DHS Admin. Claiming Unit Fax: 565-4785

Manager Approval Printed Name / Signature: _____

From Program Name: _____ Date: _____

Prepared by: _____ Phone Number: _____

Directions: Please call Department of Health Services/ Claiming Unit at 707-565-4861 for any questions regarding Avatar corrections. County staff and Contractors are to use this form to make any billing corrections (for Avatar) and fill in all information below. **County clerical staff** must complete this form and attach a copy of the Progress Note to the form, except when the services are entered in Client Charge Input in which case a copy of the Client Ledger must be attached.

Error Types: SELECT ONE:

- | | |
|---|--|
| <input type="checkbox"/> Duplicate Service | <input type="checkbox"/> Incorrect Location |
| <input type="checkbox"/> Incorrect Client/Number | <input type="checkbox"/> Incorrect Procedure Code |
| <input type="checkbox"/> Incorrect Practitioner | <input type="checkbox"/> No Progress Note |
| <input type="checkbox"/> Incorrect Date | <input type="checkbox"/> Non-Billable Service |
| <input type="checkbox"/> Incorrect Duration | <input type="checkbox"/> Note Written to Incorrect Program |
| <input type="checkbox"/> Group Correction | |
| <input type="checkbox"/> Other (Please Explain in detail) _____ | |

Original Service Information:

Program Name: _____	RU #: _____	Episode # (SCBH Only): _____
Client Name: _____	Client #: _____	
Written On Date: _____	Time: _____	Service Date: _____
	Duration (Minutes): _____	
Procedure Code: _____	Group Count: _____	Location: _____
Practitioner Name and #: _____		
Co-Practitioner Name and #: _____	Duration (Minutes): _____	Total \$ _____

Correct Service Information:

Program Name: _____	RU #: _____	Episode # (SCBH Only): _____
Client Name: _____	Client #: _____	
	Time: _____	Service Date: _____
	Duration (Minutes): _____	
Procedure Code: _____	Group Count: _____	Location: _____
Practitioner Name and #: _____		
Co-Practitioner Name and #: _____	Duration (Minutes): _____	

For Claiming Use Only

Corrected By: _____ On Date: _____

Type of Correction: V&R Deleted Edited Claimed?: Y N