Corrected Claim Request

This form is to be used by providers to submit a corrected claim.
Do Not Use the Appeal Request Form

To submit, please complete this form, attach corrected claim and fax to:
(434) 947-4465

or mail to: Piedmont Community Health Plan, Inc. – Claims Dept.
1920 Atherholt Road
Lynchburg, Virginia 24501

Date Completed:	
Corrected Claim Request Submitted by:	

Additional Notes or Explanation: