

PASRR/LOC Data Correction Form

Purpose: Use this form to correct or modify non-clinical data on a previously submitted PASRR/LOC. This form cannot be used to request a PASRR/LOC re-determination, nor does it take the place of a PASRR/LOC request. Please allow up to 30 days for processing.

Attachments: Attachments are not required with this form.

Fax this form to: (855) 709-6847

Questions: If you have any questions, please call Nevada Medicaid at (800) 525-2395.

DATA CORRECTION REQUEST DATE <i>(Enter the date <u>this</u> form is submitted.):</i>	
NOTES:	
REQUESTING PROVIDER <i>(Enter information as originally submitted on the PASRR/LOC.)</i>	
Provider Name:	NPI:
Contact Name:	
Phone:	Fax:
RECIPIENT INFORMATION <i>(Enter information as originally submitted on the PASRR/LOC.)</i>	
Recipient Name:	SSN:
Date of Birth:	Recipient ID:
Admission Date or Begin Date of Service:	
Discharge Date:	
REVISIONS <i>(Check the box(es) next to the information that requires change, then enter the revised information in the space provided.)</i>	
<input type="checkbox"/> Recipient First Name:	
<input type="checkbox"/> Recipient Middle Initial:	
<input type="checkbox"/> Recipient Last Name:	
<input type="checkbox"/> Recipient Address:	
<input type="checkbox"/> Recipient SSN:	
<input type="checkbox"/> Recipient DOB:	
<input type="checkbox"/> Provider NPI:	
<input type="checkbox"/> Other <i>(specify):</i>	