ILRC
Resources for Persons with Disabilities

3033 W 2nd Street N
Wichita, KS 67203
TEL 316 · 942 · 6300
FAX 316 · 942 · 0914
TFN 800 · 479 · 6861

CLAIM CORRECTION FORM

ATTN: CLAIM CORRECTION FORMS MAY NOT BE USED FOR BOTH A CLOCK IN AND CLOCK OUT. AT LEAST ONE TIME ENTRY MUST BE DONE THROUGH ATHENTICARE FOR THERE TO BE A VALID SHIFT.

DO NOT LIST MORE THAN ONE (1) DAY ON THIS FORM, IT WILL NOT BE PROCESSED. IF THIS FORM IS MISSING ANY INFORMATION IT WILL RESULT IN YOUR CLAIM BEING DENIED. BE CERTAIN THAT ALL FIELDS PERTAINING TO YOUR SHIFT ARE COMPLETED BELOW BEFORE SUBMITTING THIS FORM.

YOU MAY FAX THIS FORM TO 316-942-1061, MAIL IT OR DROP IT OFF AT OUR OFFICE DURING NORMAL BUSINESS HOURS OF 8AM TO 4PM, MONDAY - FRIDAY.

IF YOU NEED ADDITIONAL CORRECTION FORMS YOU CAN PICK THEM UP AT OUR OFFICE OR REQUEST A FORM TO BE SENT TO YOU ELECTRONICALLY, PLEASE CONTACT THE PAYROLL DEPT AT 316-942-6300. YOU MAY ALSO OBTAIN FORMS ON OUR WEBSITE AT: http://ilrcks.org/programs-services/payroll-services

DAYTIME HOURS PCS/PAS SERVICES ONLY BELOW: **TIME CANNOT EXCEED 12 HOURS IN A 24 HOUR PERIOD.**

1. **CUSTOMERS NAME (PRINT):** ____________________
2. **CUSTOMERS PHONE NUMBER:** ____________________
3. **DIRECT SUPPORT WORKERS NAME & ID # (PRINT):** ____________________
4. **DATE OF CORRECTION:** ____________________
5. **CLOCK IN TIME (AM / PM):** ____________ **CLOCK OUT TIME (AM / PM):** ____________
6. **ACTIVITY CODE(S):** ____________________
7. **REASON FOR CORRECTION:** ____________________

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NIGHT SUPPORT (ECS SERVICES) ONLY BELOW: **TIME CAN BE NO MORE THAN 6 TO 9 HOURS PER NIGHT.**

1. **CUSTOMERS NAME (PRINT):** ____________________
2. **CUSTOMERS PHONE NUMBER:** ____________________
3. **DIRECT SUPPORT WORKERS NAME & ID # (PRINT):** ____________________
4. **DATE OF CORRECTION:** ____________________
5. **CLOCK IN TIME (AM / PM):** ____________ **CLOCK OUT TIME (AM / PM):** ____________
6. **REASON FOR CORRECTION:** ____________________

Corrections are limited to 6 per month. Any corrections in excess of this limit will result in corrective action procedures. Any customer who has worker(s) who have exceeded the monthly limit 2 or more times will not be eligible for any corrections of errors or omissions for any of their worker without possible additional fees.

By signing below, you are confirming that the information above is accurate per guidelines stated by Medicaid for your Home and Community Based Services (HCBS). Fraudulent submissions will be reported to the State of Kansas and to your MCO.
NO ELECTRONIC SIGNATURES WILL BE ACCEPTED ON THIS FORM.

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Customer Signature **Direct Support Worker Signature**

Revised 05/24/2024