

Agreement #: H-_____

Sponsor Name: _____

Claims Revision Form

Claim Month: _____

Provider: _____ Amount: _____

Provider: _____ Amount: _____

Provider: _____ Amount: _____

Provider: _____ Amount: _____

Provider: _____ Amount: _____

Provider: _____ Amount: _____

(Use another form if more spaces needed)

Total Revision:

_____ Operating

_____ Administrative

_____ Total

Once the claim has been opened, then you must click the "SELECT" button on the Inactive claim.

Next, go to the provider's name, and make any adjustments needed. Enter the correct amounts that should have been paid the first time.

View the claim summary, and verify that the claim total is the correct amount; then certify the claim.

SDE office use only-

Date received: _____

Date entered: _____

Agreement #: H-_____

Sponsor Name: _____

Claim Month _____

Provider Name: _____

Provider Site Number: _____

Provider Tier: _____

Item	Previous Claim	Revised Claim	\$ amount of change	Correct total
Number of days claimed			N/A	N/A
Breakfast				
AM Snack				
Lunch				
PM Snack				
Supper				
Late Snack				
Total operating revision				

Reason for Revision: _____

Provider Name: _____

Provider Site Number: _____

Provider Tier: _____

Item	Previous Claim	Revised Claim	\$ amount of change	Correct total
Number of days claimed			N/A	N/A
Breakfast				
AM Snack				
Lunch				
PM Snack				
Supper				
Late Snack				
Total operating revision				

Reason for Revision: _____

Agreement #: H-_____

Sponsor Name: _____

Claim month _____

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