

Refund Check Information Form

Please fill out this form when sending in a refund check. Be sure to submit your correspondence to the Provider Service address indicated on your Explanation of Benefits (EOB). To ensure timely and accurate processing of your refund check, please provide the following information:

Patient name _____
 Member/Policy holder name _____
 Identification number _____
 Claim number _____
 Date of service(s) _____
 Amount of refund _____

The above information is required. We cannot accept a refund without the information above.

Reason for refund

Not our patient Billed in error
 Incorrect provider Duplicate payment
 Worker comp No fault
 *Paid prime should be secondary to Medicare coverage
(If available, attach a copy of the Medicare HIB card)

Paid prime should be secondary to another insurance carrier
(If checked, fill out below)

Other carrier's name _____
 Contract or policy number _____
 Effective date with other carrier _____
 Policy holder's name _____
 Policy holder's employer _____

Other (please explain) _____

*If a refund check was requested by us, please include a copy of the letter.
 *If EOB (Explanation of Benefits) is available, please attach and return along with this form and explanation.