Insurance Refund Request Form

1 Date prepared: _____

2 Prepared By/PH #: _____ 3 Department: _____

4 Patient Name: _____
(Last) (First)

5 Case #: _____ Case #: _____

6 Invoice #: _____ Invoice #: _____

7 Doctor #: _____ Doctor #: _____

8 Amount: _____ Amount: _____

9 Date of Service: _____ Date of Service: _____

10 CHG DTL: _____ 11 PMT DTL: _____ CHG DTL: _____ PMT DTL: _____

12 Refund to (Payee):
Company Name: _____

Address: _____

_____

_____

13 Subscriber Name: _____

14 Insurance ID #: _____ 15 Policy / Group #: _____

16 Attachments: ____EOB ____Insurance Letter ____Screen Print ___Purged Report

17 Payee Tax ID #: _____ 18 Insurance Address and Information Verified _____

19 Please Check Reason For Refund:
____ Insurance Overpayment
____ Duplicate Payment
____ Paid Incorrect Provider Rate
Adjustment: _____

20 **Total Refund Due**: _____
____ Charge in Error
____ Secondary Insurance Overpayment
____ Other: _____

COMMENTS:

REFUNDS WILL NOT BE PROCESSED WITHOUT THE PROPER SIGNATURE(S)
Supervisor/Assistant Director Name: _____
Supervisor/Assistant Director Signature: _____
NOTICE
Refunds under $500.00 require Supervisor signature.
Refunds over $500.00 require Assistant Director Signature

EXAMPLE - B

Revised 12/8/2010