



# SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services  
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

## Refund Check Details (To be completed by Provider and mailed with Refund Check)

### PROVIDER INFORMATION

Provider Name: \_\_\_\_\_ Provider Contract: \_\_\_\_\_

Check Date: \_\_\_\_\_ Phone/Extension: \_\_\_\_\_

Check Amount: \_\_\_\_\_ Email Address: \_\_\_\_\_

### REFUND CHECK INFORMATION

Consumer: \_\_\_\_\_ RA Claim Number: \_\_\_\_\_

Service Code: \_\_\_\_\_ Provider Direct Number: \_\_\_\_\_

Service Date (s): \_\_\_\_\_

### REFUND CHECK INFORMATION

Consumer: \_\_\_\_\_ RA Claim Number: \_\_\_\_\_

Service Code: \_\_\_\_\_ Provider Direct Number: \_\_\_\_\_

Service Date (s): \_\_\_\_\_

### REFUND CHECK INFORMATION

Consumer: \_\_\_\_\_ RA Claim Number: \_\_\_\_\_

Service Code: \_\_\_\_\_ Provider Direct Number: \_\_\_\_\_

Service Date (s): \_\_\_\_\_

### REFUND REASON

Provider Billing Error: \_\_\_\_\_ Patient Liability: \_\_\_\_\_ Other Primary Insurance: \_\_\_\_\_ Duplicate Payment: \_\_\_\_\_

Other (Reason): \_\_\_\_\_

**Note: Attach all supporting documentation.**

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### (FOR REIMBURSEMENT USE ONLY)

Deposit Date: \_\_\_\_\_ Comments: \_\_\_\_\_

Posted Date: \_\_\_\_\_

P.O. Box 9, West End, NC 27376  
24-Hour Access to Care Line: 800-256-2452  
Serving Anson, Guilford, Harnett, Hoke, Lee, Montgomery,  
Moore, Randolph & Richmond counties

