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 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.

(FOR REIMBURSEMENT USE ONLY)
Deposit Date: ___________________  Comments: ___________________
Posted Date: ___________________