Leading the Way to Quality Care

Provider Claim Refund Form

To ensure your refund is handled appropriately, we request that you complete the Provider Refund Claim Form in its entirety. If your refund contains more than one claim or patient account, please complete the attached form or attach a copy of your own file.

All checks should be made payable to Prestige Health Choice. Your refund check and completed form should be mailed to:

Prestige Health Choice
Attention: Provider Refund Unit
PO Box 7367
London, KY 40742

Provider Information:

Date: ______________________ Provider Name: ______________________

NPI: ______________________ TIN: ______________________

Provider Address: ______________________

Office Contact: ______________________ Phone Number: ______________________

Member Information:

Member Name	ID Number	Date of Service	Claim Number	Refund Amount

Please note: if your refund contains more than one claim, please use the attached form (page 2) or attach own file.

Type of Refund:

☐ Medical Overpayment
☐ Capitation

Other: ______________________

Reason for Refund:

☐ Other insurance (Attach primary EOB)
☐ Subrogation
☐ Duplicate payment
☐ Claim was processed under the incorrect provider
☐ Incorrect provider cashed check
☐ Not our check
☐ Billing error
☐ Contract change/Fee schedule update
☐ Eligibility
☐ Recovery project (Please include project letter.)
☐ Bonus payment
☐ Return supplies (Durable Medical Equipment)
☐ Other: (Please provide details. “Overpayment” is not a valid reason.)

____

____

Additional Claim Form

If your refund contains more than one claim, please complete the form below or attach your own file.

Member Name	ID Number	Date of Service	Claim Number	Refund Amount	Reason for Refund
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	

P2203_1603