

## Provider Overpayment Refund Submission Form

### INSTRUCTIONS

This form should be used anytime you are submitting a refund to MedStar Family Choice.

1. Complete this form and include it with your refund so we can properly apply the check.
2. Use a separate form for each member included on the enclosed refund check.
3. Attach a copy of the original provider voucher, along with additional information that might assist in processing refund.
4. For multiple claims, print the attached spreadsheet with a list of all claim numbers involved.

**Important:** Before issuing a refund, please verify that the accounts receivable reflected on your provider voucher has not already been satisfied.

Please select one:       Immediate Recoupment of Payment       Refund Check Attached

### INFORMATION

Provider/Practice Name:	Date:
Provider TIN:	Date of Service:
Member Name:	Claim #:
Member ID:	Refund Amount:

### REASON FOR REFUND

- Billed in error
- Returned product (DME/Supplies)
- COB (If other insurance is primary, please attach the primary EOB)
- Subrogation/Worker's compensation (please attach document from carrier)
- Not our patient
- Processed under wrong NPI (be sure to include correct NPI)
- Duplicate payment
- Other (Comments required)

### ADDITIONAL COMMENTS

### CONTACT INFORMATION

Contact Person:	Contact Phone #:	Contact Email:
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**Mail to: MedStar Family Choice**  
 Maryland Claims  
 P.O. Box 2189  
 Milwaukee, WI 53201

