## Provider Claim Refund Form





Your satisfaction is important to us. To ensure your refund is handled to the best of our ability, we request that you fully complete the Provider Claim Refund Form. The form enables us to credit your account in a timely manner. If your refund contains more than one claim, please complete the attached form or attach your own file.

Provider address:  Office contact:  Phone number:  Firollee information  Enrollee name  ID number  Date of service  Claim number  Refund an \$  Please note: If your refund contains more than one claim, please used the attached form (page 2) or attach your own file  Type of refund  Medical overpayment  Capitation  Cher:  Reason for refund  Other insurance (attach primary EOB)  Duplicate payment  Claim was processed under the incorrect provider   Incorrect provider cashed check  Billing error  Contract change or fee schedule update  Eligibility  Recovery project (please include project letter)	Date:			name:			
Office contact:  Phone number:  Enrollee information  Enrollee name  ID number  Date of service  Claim number  Refund an \$  Please note: If your refund contains more than one claim, please used the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the attached form (page 2) or attach your own file that the please of the please of the attached form (page 2) or attach your own file that the please of the please of the attached form (page 2) or attach your own file that the please of the please of the attached form (page 2) or attach your own file that the please of the	NPI:			TIN:			
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Please note: If your refund contains more than one claim, please used the attached form (page 2) or attach your own file  Type of refund  Medical overpayment	Office contact:		Phone r	Phone number:			
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Type of refund  Medical overpayment					\$		
□ 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 or fee schedule update   □ Eligibility □ Recovery project (please include project letter)	Please note: If your refun	d contains more than one	e claim, please used the	attached form (page 2) or a	attach your own file.		
Reason for refund  Other insurance (attach primary EOB)  Duplicate payment  Incorrect provider cashed check  Billing error  Eligibility  Subrogation  Claim was processed under the incorrect provider  Not our check  Contract change or fee schedule update	Type of refund						
Reason for refund  Other insurance (attach primary EOB) Duplicate payment Incorrect provider cashed check Billing error Contract change or fee schedule update Bilgibility Recovery project (please include project letter)	☐ Medical overpayment		☐ Capi	☐ Capitation			
□ 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 or fee schedule update         □ Eligibility       □ Recovery project (please include project letter)	Other:						
□ 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 or fee schedule update         □ Eligibility       □ Recovery project (please include project letter)							
□ Duplicate payment       □ Claim was processed under the incorrect provider         □ Incorrect provider cashed check       □ Not our check         □ Billing error       □ Contract change or fee schedule update         □ Eligibility       □ Recovery project (please include project letter)							
□ Incorrect provider cashed check       □ Not our check         □ Billing error       □ Contract change or fee schedule update         □ Eligibility       □ Recovery project (please include project letter)	Reason for refund						
□ Billing error □ Contract change or fee schedule update □ Eligibility □ Recovery project (please include project letter)		ch primary EOB)	☐ Subr	ogation			
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Bonus payment Return supplies (durable medical equipment)	<ul> <li>□ Other insurance (attachment)</li> <li>□ Duplicate payment</li> <li>□ Incorrect provider cashment</li> <li>□ Billing error</li> </ul>	· · · · · · · · · · · · · · · · · · ·	☐ Clair ☐ Not ☐ Conf	n was processed under the in our check ract change or fee schedule	update		
Other (Please provide details. "Overpayment" is not a valid reason.)	<ul> <li>□ Other insurance (attachment)</li> <li>□ Duplicate payment</li> <li>□ Incorrect provider cashment</li> <li>□ Billing error</li> </ul>	· · · · · · · · · · · · · · · · · · ·	☐ Clair ☐ Not ☐ Cont	n was processed under the in our check ract change or fee schedule	update project letter)		

## All checks should be made payable to Keystone First - CHIP.

Mail to:

Keystone First – CHIP Attention: Provider Refunds P.O. Box 21152 Eagan, MN 55121

## **Additional Claim Form**

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

Enrollee name	ID number	Date of service	Claim number	Refund amount	Reasons for claim
				\$	
				\$	
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Print form



