

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 Refund Claim Form. The form enables us to credit your account in a timely manner. If your refund contains more than one claim, please complete the form on page 2 or attach your own file.

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 your own file.

Type of refund	
<input type="checkbox"/> Medical overpayment	<input type="checkbox"/> Capitation
Other:	

Reason for refund	
<input type="checkbox"/> Other insurance (attach primary EOB)	<input type="checkbox"/> Subrogation
<input type="checkbox"/> Duplicate payment	<input type="checkbox"/> Claim was processed under the incorrect provider
<input type="checkbox"/> Incorrect provider cashed check	<input type="checkbox"/> Not our check
<input type="checkbox"/> Billing error	<input type="checkbox"/> Contract change or fee schedule update
<input type="checkbox"/> Eligibility	<input type="checkbox"/> Recovery project (please include project letter)
<input type="checkbox"/> Bonus payment	<input type="checkbox"/> Return supplies (durable medical equipment)
Other (Please provide details. "Overpayment" is not a valid reason.)	

**All checks should be made payable to
Keystone First Community HealthChoices.**

Mail to:

Attn: Claims Repayment Research Unit
Keystone First Community HealthChoices
P.O. Box 7146
London, KY 40742-7146



Keystone First
Community HealthChoices

Additional Claim Form

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

Member name	ID number	Date of service	Claim number	Refund amount	Reasons for claim
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Print form



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