

## **Refund Form**

**Instructions for Providers:** Highmark Wholecare cannot accept verbal requests to retract claim(s) overpayments. Providers may complete and submit a Refund Form or a letter that contains all of the information requested on this form.

This form, together with all supporting materials relevant to the claim(s) reversal request being made including but not limited to EOB from other insurance carriers and your refund check should be mailed to:

PNC BANK, c/o HIGHMARK WHOLECARE/REFUNDS, Lock Box #645171, 500 1st Avenue, Pittsburgh, PA 15219.

## **PLEASE COMPLETE**

DateGroup Name		Group Number		
Address		Phone Number		
Practitioner Name		Individual Provider Number		
Vendor Name		Tax Identification Number		
Contact Person at Provider's Office		Phone Number		
E-mail Address				
Name of Claims to f	ormation:			
Member/Claim Info	offiliation.			
Name	Member ID #			
Name	Member ID #			Refund Amount
Reason for Refun  Payment of Medicare	Member ID #  Ind:  If Outstanding Credit Balance AR  Indicated (Medicaid Member)			

Four Gateway Center | 444 Liberty Avenue | Suite 2100 | Pittsburgh, PA 15222-1222 | 412-255-4640 | HighmarkWholecare.com

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association ("Highmark Wholecare").