



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

Date _____ Group 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 _____

Member/Claim Information:

Name	Member ID #	DOS	Claim Number	Refund Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Reason for Refund:

- Payment of Outstanding Credit Balance AR
- Medicare
- Auto-Insurance Identified (Medicaid Member Only)
- Unable to Identify Patient

Comment: _____

