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:

PA Checks and Refunds
PO Box 890135
Camp Hill, PA 17089

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:

_____
_____
_____