Refund Check Details

Provider Information

Provider Name: _____ Provider Contact: _____

Check Date: _____ Phone/Extension: _____

Check Amount: _____ Email: _____

Member: _____ RA Claim Number: _____

Service Code: _____ RA Date: _____

Service Dates:

_____

Refund Check Information

Member: _____ RA Claim Number: _____

Service Code: _____ RA Date: _____

Service Dates:

_____

Member: _____ RA Claim Number: _____

Service Code: _____ RA Date: _____

Service Dates:

_____

Refund Reason

Provider Billing Error: _____ Patient Liability: _____

Other Primary Insurance: _____ Duplicate Payment: _____

Other:

_____

For Reimbursement Use Only

Deposit Date: _____ Posted Date: _____

Comments:

_____