



Refund Check Details

PROVIDER INFORMATION

Provider Name: _____ Provider Contact: _____
 Check Date : _____ Phone/Extension: _____
 Check Amount: _____ Email Address: _____

REFUND CHECK INFORMATION

Consumer: _____ RA Claim Number: _____
 Service Code: _____ Provider Direct #: _____
 Service Date(s): _____

REFUND CHECK INFORMATION

Consumer: _____ RA Claim Number: _____
 Service Code: _____ Provider Direct #: _____
 Service Date(s): _____

REFUND CHECK INFORMATION

Consumer: _____ RA Claim Number: _____
 Service Code: _____ Provider Direct #: _____
 Service Date(s): _____

REFUND REASON

Provider Billing Error: _____ Patient Liability: _____
 Other Primary Insurance: _____ Duplicate Payment: _____
 Other (Reason): _____

NOTE – Attach all supporting documentation.

FOR REIMBURSEMENT USE ONLY

Deposit Date: _____ Comments: _____
 Posted Date: _____

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