PARTNERS HEALTH PLAN

# Overpayment Refund/Notification Form

Please complete this form and include it with your unsolicited refund so that we can properly post the refund. If a check is included with this correspondence, please make it payable to Partners Health Plan and submit it with any supporting documentation.

| Provider/Physician/Supplier Name | Contact Person | Phone # |
|---|---|---|
| Address | Check # | Check Date |
| Tax ID # | Check Amount $ | |

**REFUND INFORMATION**

Please provide the following information for the claim being refunded. For multiple claims, complete the attached spreadsheet with a list of all claim numbers involved.

| Member Name | Partners Health Plan Claim # |
|---|---|
| Date of Service | Member ID # |
| Claim Amount Refunded $ | |

Reason Codes: (check one)

- ☐ Duplicate Payment
- ☐ Billing Error (Wrong Amount Billed)
- ☐ Wrong Provider
- ☐ Other: (provide detailed description)

_____

_____

Mail to:

Partners Health Plan
c/o HealthSmart
P.O. Box 240356
Apple Valley, MN 55124

PHP PARTNERS HEALTH PLAN

This spreadsheet should be used to submit multiple refunds included in a single check.

Please supply all available information, including a claim number to help ensure the proper posting of your check. Additional documentation, such as a Statement of Remittance (SOR), is also helpful and should be submitted if available.

Please be specific when completing the Reason for Overpayment column and make sure your check total equals the claim totals identified.

| Member ID # | Member Name | PHP Claim # | Date of Service | Claim Amount Refunded $ | Reason for Overpayment | Comments |
|---|---|---|---|---|---|---|
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