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)

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Mail to:

Partners Health Plan
c/o HealthSmart
2929 Expressway Drive North, Suite 210
Hauppauge, NY 11749

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