

## Overpayment Refund Notification Form

In order for an overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is a UniCare Health Plan of West Virginia, Inc. (UniCare) check, please include a completed form specifying the reason for the check return.

Provider name/contact:		Contact number:	
Patient account number:		Patient name:	
Member ID number:		DCN number:	
Provider ID:		Provider TIN:	
Date of service:		to	
			Total billed charges: \$
Total check amount:			\$

Claim number(s):


Reason for refund or check return:

- |   |  |
|---|--|
| <input type="checkbox"/> UniCare letter<br><input type="checkbox"/> Contract rate change<br><input type="checkbox"/> Duplicate payment<br><input type="checkbox"/> Incorrect member<br><input type="checkbox"/> Incorrect provider<br><input type="checkbox"/> Other (Please explain.): | <input type="checkbox"/> Negative balance<br><input type="checkbox"/> Other health insurance/third-party liability<br><input type="checkbox"/> Payment error<br><input type="checkbox"/> Billed in error/adjusted charge |
|---|--|

All refund checks should be mailed with a copy of this form to:  
 UniCare Health Plan of West Virginia, Inc.  
 Attn: Overpayment Recovery — WV  
 P.O. Box 73651  
 Cleveland, OH 44193-1177

Once the UniCare Cost Containment Unit has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this *Overpayment Refund Notification Form*.