Provider Claim Refund Form

Your satisfaction is important to us. To ensure your refund is handled to the best of our ability, we request that you fully complete the Provider Claim Refund Form. The form enables us to credit your account in a timely manner. If your refund contains more than one claim, please complete the form on page 2 or attach your own file.

Provider information	
Date:	Provider name:
NPI:	TIN:
Provider address:	
Office contact:	Phone number:

Member information				
Member name	ID number	Date of service	Claim number	Refund amount
				$

Type of refund	
☐ Medical overpayment	☐ Capitation
Other:	

Reason for refund	
☐ Other insurance (attach primary EOB)	☐ Subrogation
☐ Duplicate payment	☐ Claim was processed under the incorrect provider
☐ Incorrect provider cashed check	☐ Not our check
☐ Billing error	☐ Contract change or fee schedule update
☐ Eligibility	☐ Recovery project (Please include project letter.)
☐ Bonus payment	☐ Return supplies (durable medical equipment)
Other (Please provide details. “Overpayment” is not a valid reason.)	

All checks should be made payable to AmeriHealth Caritas.

Mail to: Attn: Claims Processing Department
AmeriHealth Caritas North Carolina
P.O. Box 7380
London, KY 40742-7380

AmeriHealth Caritas North Carolina

Additional Claim Form

If your refund contains more than one claim, please complete the attached form or attach your own file.

Member name	ID number	Date of service	Claim number	Refund amount	Reasons for claim
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
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				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	
				$	

Print form

AmeriHealth Caritas North Carolina