dell children's
HEALTH PLAN

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 from Dell Children's Health Plan, please include a completed form specifying the reason for the check return.

Provider name/contact: _____ **Contact number:** _____

Provider ID: _____ **Provider tax ID:** _____

Subscriber ID: _____

Document control number (displayed on letter from Cost Containment Unit): _____

Member name: _____ **Member account number:** _____

Dates of service: _____

Total billed charges: $_____

Total check amount: $_____

Claim number(s):

Reason for refund or check return:

☐ Letter from Dell Children's Health Plan ☐ Contract rate change ☐ Duplicate payment
☐ Billed in error/adjusted charge ☐ Incorrect provider ☐ Negative balance
☐ Other health insurance/third-party liability ☐ Payment error ☐ Incorrect member
☐ Other: _____

All refund checks should be mailed with a copy of this form to:

Dell Children's Health Plan
P.O. Box 933657
Atlanta, GA 31193-3657

Once the 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*.