AmeriHealth Caritas Florida

Provider Claim Refund Form

To ensure your refund is handled appropriately, we request that you complete the Provider Refund Claim Form in its entirety. If your refund contains more than one claim or patient account, please complete the attached form or attach a copy of your own file.

All checks should be made payable to AmeriHealth Caritas Florida. Your refund check and completed form should be mailed to: **AmeriHealth Caritas Florida Attention: Provider Refund Unit P.O. Box 7367, London, KY 40742.**

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

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

Please note: if your refund contains more than one claim, please use the attached form (page 2) or attach your own file.

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/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.)	

Additional Claim Form

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

Member name	ID number	Date of service (mm/dd/yy)	Claim number	Refund amount	Reason for refund
				$	