

Provider Information

Name:

Address:

Contact Name:

Phone Number:

National Provider Identifier (NPI) Number(s):

Refund Information

1 | Group Number: _____ Subscriber I.D. Number _____

Service Date: _____ Claim Number: _____

Refund Amount: _____ Patient Name: _____

Explanation:

INTERNAL USE ONLY Account: _____ Reason: _____ System: _____

2 | Group Number: _____ Subscriber I.D. Number _____

Service Date: _____ Claim Number: _____

Refund Amount: _____ Patient Name: _____

Explanation:

INTERNAL USE ONLY Account: _____ Reason: _____ System: _____

3 | Group Number: _____ Subscriber I.D. Number _____

Service Date: _____ Claim Number: _____

Refund Amount: _____ Patient Name: _____

Explanation:

INTERNAL USE ONLY Account: _____ Reason: _____ System: _____

4 | Group Number: _____ Subscriber I.D. Number _____

Service Date: _____ Claim Number: _____

Refund Amount: _____ Patient Name: _____

Explanation:

INTERNAL USE ONLY Account: _____ Reason: _____ System: _____

5 | Group Number: _____ Subscriber I.D. Number _____

Service Date: _____ Claim Number: _____

Refund Amount: _____ Patient Name: _____

Explanation:

INTERNAL USE ONLY Account: _____ Reason: _____ System: _____