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 an Amerigroup check, please include a completed form specifying the reason for the check return.

Provider Name/Contact:	**Contact Number:**
Patient Account Number:	**Member Name:**
Subscriber ID:	**DCN Number (Displayed on CCU Letter):**
Provider ID:	**Provider Tax Identification Number:**
Date of Service: [to]	**Total Billed Charges: $**

Total Check Amount: $________________________

Claim Number(s):

Reason for Refund or Check Return:

☐ Amerigroup Letter

☐ Contract Rate Change

☐ Duplicate Payment

☐ Incorrect Member

☐ Incorrect Provider

☐ Negative Balance

☐ Other Health Insurance/ Third Party Liability

☐ Payment Error

☐ Billed in Error/Adjusted Charge

☐ Other:

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

Amerigroup
P.O. Box 933657
Atlanta, GA 31193-3657

Once Amerigroup’s 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.