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	
Provider ID	
Provider tax ID	
Subscriber ID	
DCN number (Displayed on CCU Letter)	
Member name	
Member account number	
Date of service	
Total billed charges	

Total check amount: $_____

Claim number(s):

Reason for refund or check return:

☐ Health plan 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 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*.