



An Anthem Company

providers.amerigroup.com

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 Iowa, Inc. 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:

- 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 Iowa, Inc.
P.O. Box 933657
Atlanta, GA 31193-3657

Once the Amerigroup 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.