



**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.

<b>Provider Name/Contact</b> _____
<b>Contact Number</b> _____
<b>Provider ID</b> _____
<b>Provider Tax ID</b> _____
<b>Subscriber ID</b> _____
<b>DCN Number (Displayed on CCU Letter)</b> _____
<b>Member Name</b> _____
<b>Member Account Number</b> _____
<b>Date of Service: [to]</b> _____
<b>Total Billed Charges: \$</b> _____

**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 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.