CREATING HEALTHCARE SOLUTIONS

Provider Identified Overpayment Form

This form may be utilized by Providers when an overpayment has been identified by the Provider Business Office. A copy of this form should accompany the refund payment made to the Alliance.

Provider Name: _____

Provider Billing #: _____ Provider Phone #: _____

Provider Address: _____

Patient Name: _____ Patient Alliance ID#: _____

Date(s) of Service: _____

Claim Number(s): _____

Refund Amount: _____ Check #: _____

Reason for Refund (Check all that apply)

☐ Not our Patient/Wrong Provider

☐ Duplicate Payment

☐ Wrong Procedure Code

☐ Patient has Other Health Coverage *(please attach copy of EOB from OHC/CCS)*

☐ Patient has Medicare *(please attach copy of EOB from Medicare)*

☐ Other *(please specify)*: _____

Please enclose a copy of this form with your refund so we can apply the refund to the correct patient account. Please mail refund payable to:

Central California Alliance for Health
ATTN: Recoveries Administrator
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-9998

If you are not sending a refund, this form can be emailed or faxed to:

Email: RecoveriesAdmin@ccah-alliance.org
Fax: (831) 430-5871

If you have any questions, please contact the Recoveries Administrator at (831) 430-2505.