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.