Amerigroup

Overpayment Refund Notification Form

In order for the 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 Community Care check, please include a completed form specifying the reason for the return of the check.

Provider information	
Provider name/contact:	
Contact number:	Provider ID:
NPI number:	Provider tax ID:
Subscriber ID:	DCN number (Displayed on CCU letter):

Member information	
Member name:	
Member account number:	Date of service:
Total billed charges:	Claim number:

Overpayment information	
Total check amount:	Date overpayment identified:
Date range/time frame the issue(s) occurred:	Specific CPT/HCPCS/DRG code(s) involved with the reimbursement:
Have you performed due diligence to ensure this voluntary refund is isolated only to the identified claim(s)? ☐ Yes ☐ No	
Did you self-identify the overpayment? ☐ Yes ☐ No	
If no, then briefly explain who identified the overpayment and issues or billing codes that were identified.	

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Additional claim(s)			
Claim number	Member name	Member account #	Date of service

Reason for refund or check return:

☐ Amerigroup letter   ☐ Negative balance

☐ Contract rate change   ☐ Other health insurance/third-party liability

☐ Duplicate payment   ☐ Payment error

☐ Incorrect member   ☐ Billed in error/adjusted charge

☐ Incorrect provider   ☐ Other: _____

All refund checks should be mailed with a copy of this form to:
Amerigroup Community Care
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*.