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 Washington, Inc. check, please include a completed form specifying the reason for the check return.

Provider name/contact:	**Contact number:**
Patient account number:	**Member name:**
Subscriber ID:	**DCN number (Displayed on *CCU Letter*):**
Provider ID:	**Provider tax identification number:**
Date of service: [to]	**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 Washington, Inc.
P.O. Box 933657
Atlanta, GA 31193-3657

Once Amerigroup's 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*.