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 a Wellpoint 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: [to] ______________________________

Total Billed Charges: $ ______________________________

Total Check Amount: $ ______________________________

Claim Number(s):

Reason for Refund or Check Return:

□ Wellpoint 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:

Wellpoint
P.O. Box 933657
Atlanta, GA 31193-3657

Once the Wellpoint 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.

Wellpoint members in the Medicaid Rural Service Area and the STAR Kids program are served by Wellpoint Insurance Company; all other Wellpoint members in Texas are served by Wellpoint Texas, Inc.

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