



Overpayment Refund Notification Form

For overpayment refunds 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 phone number:		Provider ID:	
Provider tax ID:		Subscriber ID:	
DCN number (displayed on the CCU letter):			

Member name:			
Member account number:			
Date of service:	[to]	Total billed charges:	\$

Total check amount:	\$
---------------------	----

Claim numbers:

Reason for refund or check return:

<input type="checkbox"/> Wellpoint letter <input type="checkbox"/> Incorrect provider <input type="checkbox"/> Incorrect member	<input type="checkbox"/> Duplicate payment <input type="checkbox"/> Payment error <input type="checkbox"/> Negative balance	<input type="checkbox"/> Billed in error/adjusted charge <input type="checkbox"/> Other health insurance/third party liability <input type="checkbox"/> Contract rate change
Other:		

All refund checks should be mailed with a copy of this form to:

<https://provider.wellpoint.com/md/>

Services provided by Wellpoint Maryland, Inc.

[Title/headline]

Page 2 of 2

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

Once the Cost Containment Unit (CCU) from Wellpoint has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this *Overpayment Refund Notification Form*.