

# Overpayment Refund/Notification Form

Please complete this form and include it with your unsolicited refund so that we can properly post the refund. If a check is included with this correspondence, please make it payable to Partners Health Plan and submit it with any supporting documentation.

Provider/Physician/Supplier Name	Contact Person	Phone #
Address	Check #	Check Date
Tax ID #	Check Amount \$	

## REFUND INFORMATION

Please provide the following information for the claim being refunded. For multiple claims, complete the attached spreadsheet with a list of all claim numbers involved.

Member Name	Partners Health Plan Claim #
Date of Service	Member ID #
Claim Amount Refunded \$	
Reason Codes: (check one)	
<input type="checkbox"/> Duplicate Payment <input type="checkbox"/> Billing Error (Wrong Amount Billed) <input type="checkbox"/> Wrong Provider <input type="checkbox"/> Other: (provide detailed description)	
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Mail to:

Partners Health Plan  
c/o HealthSmart  
2929 Expressway Drive North, Suite 210  
Hauppauge, NY 11749

