



Overpayment Refund/Notification Form

Please complete this form and include it with your refund so that we can properly apply the check and record the receipt. If a check is included with this correspondence, please make it payable to UnitedHealthcare and submit it with any supporting documentation.

Please select one (by checking the appropriate box): <input type="checkbox"/> Immediate Recoupment of Payment <input type="checkbox"/> Refund Check Attached		
Provider/Physician/Supplier Name	Contact Person and Phone #	
Address	Check #	Check Date
Tax ID #	Check Amount \$	

REFUND INFORMATION

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

Patient Name	UnitedHealthcare Claim Audit #	
Date of Service	Group #	Subscriber ID #
Claim Amount Refunded	Adjustment Reason Code – One Reason Per Claim	
If a specific patient or claim amount data are not available for all claims due to statistical sampling, please indicate methodology and formula used to determine amount and reason for overpayment.		
Reason Codes: Billing/Clerical Error - 01 Corrected Date of Service – 02 Duplicate - 03 Corrected CPT Code – 04 Not Our Patient(s) – 05 Modifier Added/Removed – 06 Billed in Error - 07	Reason Codes: Insufficient Documentation – 08 Patient Enrolled in HMO – 09 Services Not Rendered – 10 Medical Necessity – 11 Non-Credentialed provider – 12 Compliance Audit (Extrapolation Used) -13 Other (Please Specify):	
For Institutional Facilities Only		
Cost Report Year(s): If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.		

Mail to:

UnitedHealthcare Insurance Company
 P.O. Box 101760
 Atlanta, GA 30392-1760

UnitedHealthcare Insurance Company - Overnight Delivery
 Lockbox 101760
 3585 Atlanta Avenue
 Hapeville, GA 30354

Signature of Requestor:

Date:

