Overpayment refund/notification form

Please download the form, complete each field and print. Include the form with your refund so we can properly apply the refund and record the receipt. If you include a check, please make it payable to UnitedHealthcare and submit it with supporting documentation.

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 30354-1705

Please select one by checking the appropriate box:
☐ Payment recoupment/reimbursement ☐ Refund check

Health care provider/physician/supplier name:	Contact person and phone number:		
Address:	Check number:	Check date:	Check amount $:
Tax ID number (TIN):	National Provider Identifier (NPI) number:		

Refund information: Please provide the following information for a single claim. For multiple claims, print the **Overpayment – Multiple refunds request** spreadsheet.

Patient name:	UnitedHealthcare claim audit number:	
Date of service:	Group number:	Patient account number:
Subscriber ID number:	Claim amount refunded $:	

Overpayment reason code key (use 1 reason per claim)		
COB - 01 Please provide primary carrier information		
Primary carrier name:		
Primary carrier payer ID (if available):		
Primary carrier subscriber ID:		
☐ Billing/clerical error – 02	☐ Modifier added/removed – 03	☐ Medical necessity – 04
☐ Corrected date of service – 05	☐ Billed in error – 06	☐ Non-credentialed health care provider – 07

Codes continued on next page

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Overpayment refund/notification form (cont.)

Overpayment reason code key (use 1 reason per claim) (cont.)		
☐ Duplicate – 08	☐ Insufficient documentation – 09	☐ Compliance audit (extrapolation used) – 10
☐ Corrected CPT® code – 11	☐ Patient enrolled in HMO – 12	☐ Other (please specify) – 13
☐ Not our patient(s) – 14	☐ Services not rendered – 15	

If a specific patient or claim amount data is not available for the claim(s) because you are using statistical sampling, please list the methodology and formula you used to determine amount and reason for overpayment.

Signature:	**Date:**

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

Overpayment – Multiple refunds request

Use this spreadsheet to submit multiple refunds on an overpayment request from UnitedHealthcare. Print this form as many times as needed to include all submitted claims.

Please supply all available information to help ensure a proper refund. Additional documentation, such as a Provider Remittance Advice (PRA), is also helpful.

Please be specific when completing the reason for overpayment column, and make sure your check total equals the claim totals identified.

Unique identifier (UID)	Policy number	Subscriber number	Member first name	Member last name	Patient account number	Tax ID number (TIN)	Claim audit number	UnitedHealthcare check number

First service date	Last service date	Billed amount	Overpayment reason	Primary carrier name	Primary carrier payer ID	Primary carrier subscriber ID	Refund: Yes/no	Refund amount
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	

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Overpayment – Multiple refunds request (cont.)

Unique identifier (UID)	Policy number	Subscriber number	Member first name	Member last name	Patient account number	Tax ID number (TIN)	Claim audit number	UnitedHealthcare check number

First service date	Last service date	Billed amount	Overpayment reason	Primary carrier name	Primary carrier payer ID	Primary carrier subscriber ID	Refund: Yes/no	Refund amount
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	

Overpayment – Multiple refunds request (cont.)

Unique identifier (UID)	Policy number	Subscriber number	Member first name	Member last name	Patient account number	Tax ID number (TIN)	Claim audit number	UnitedHealthcare check number

First service date	Last service date	Billed amount	Overpayment reason	Primary carrier name	Primary carrier payer ID	Primary carrier subscriber ID	Refund: Yes/no	Refund amount
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	