Parkland Community Health Plan Refund Information Form

To refund a Parkland Community Health Plan overpayment, complete this form. Make the refund check payable to Parkland Community Health Plan and include a copy of the corresponding PCHP remittance that shows the remitted payment. Mail the completed form, the refund check, and the remittance to the PCHP-Financial Department at the following address:

**Parkland Community Health Plan
Attn: Refunds
PO Box 560307
Dallas TX, 75356**

A. Provider Information		
Provider Name (*please print*):		
NPI:	Taxonomy:	Benefit Code:
Street Address:		
City:	State:	ZIP:
Contact Name (*please print*)*:*		
Telephone Number with Extension:		
E-mail Address:		

B. Claim Information	
Apply refund to claim ICN number	
Patient's Name:	Patient's PCHP ID Number:
Date(s) of Service (DOS):	

C. Reason for the Refund (Choose One)	
☐PCHP audit identified overpayment- Please include recoupment letter	☐ Other Insurance paid $ _____ on this claim.
☐ Direct Payment Program (CHRIP, TIPPS, RAPPS and BHS)	**Instructions:** *If the submitted refund is because of another insurance payment, attach the other insurance Explanation of Benefits [EOB] document that shows the payment. If no EOB is available, complete the following:*
☐ Duplicate Medicaid payment	
☐ Claim paid on wrong provider's Medicaid NPI/API	Insurance Co. Name:
☐ Patient's Medicare eligibility	Address:
☐ Credit balance refund (*describe in detail*):	Telephone Number:
☐ Claim paid on wrong patient's Medicaid ID number	Policy Number:
☐ Above named person is not our patient	Telephone Number:
☐ Other refund reason (*describe in detail*):	Effective Date:
Billing Error / Service was not rendered as billed **_Do not refund. Please submit a corrected claim_**	Termination Date:
Provider Signature *(stamped signatures not accepted)*:	
Date:	