Standard Provider Refund Form

ConnectiCare, Inc. & Affiliates

Please use this form to submit your refund should you receive an overpayment from ConnectiCare, Inc.

Send to: ConnectiCare, Inc.
P.O. Box 416608
Boston, MA 02241-6608

Provider Name: _____ Date: _____

Provider ConnectiCare ID: _____

Address: _____

Authorized Signature: _____ Date: _____

Please check one of the following:

☐ Please deduct this overpayment from future remittance.

☐ I have attached a personal check to refund the overpayment.
Check No.: _____
Amount: _____

☐ I have attached the check to be voided.
Check No.: _____
Amount: _____

The following information must be completed for each refund.

Patient's Name: _____ ConnectiCare Member ID: _____

Claim Number: _____ Date(s)of Service: _____

Procedure/Service: _____ Total Charge: _____

Reason for refund (check one)

☐ Charges billed in error (explain) _____

☐ Duplicate payment

☐ Not our patient

☐ No fault insurance

☐ Paid by other insurance

☐ Workers' compensation

☐ Other (explain) _____

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