

**Standard Provider Refund Form**

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

Send to: ConnectiCare VIP Claims Refund  
P.O. Box 416947  
Boston, MA 02241-6947

Courier Delivery Address: Bank of America Merrill Lynch  
Lockbox Services  
Lockbox 416947, Ma5-527-02-07  
2 Morrissey Boulevard  
Dorchester, MA 02125

Provider name: \_\_\_\_\_ Date: \_\_\_\_\_

Provider ConnectiCare ID: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Authorized signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**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: \_\_\_\_\_

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) \_\_\_\_\_  
\_\_\_\_\_