

Standard Provider Refund Form

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

Send to: ConnectiCare, Inc
P.O. Box 32153
Hartford, CT 06150-2153

Provider name: _____ Date: _____

Provider ConnectiCare ID: _____

Address: _____

Authorized signature: _____ Date: _____

Please check one of the following:

- Requesting refund from future remittance or attached personal check.
Requesting refund with attached voided check.
Amount and Check No. fields.

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)