

# 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 416608  
Boston, MA 02241-6608

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Please check one of the following:**

- |  |  |
|--|--|
| <input type="checkbox"/> Please deduct this overpayment from future remittance.      | <input type="checkbox"/> I have attached the check to be voided. |
| <input type="checkbox"/> I have attached a personal check to refund the overpayment. | Check No.: _____   |
| Check No.: _____   | Amount: _____  |
| 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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