AMERIHEALTH OVERPAYMENT / REFUND FORM

Date _____ **Provider Number** _____
Provider Name _____
Provider Address _____

Company:
☐ 03 AmeriHealth New Jersey ☐ 08 AmeriHealth Delaware ☐ 04 AmeriHealth Pennsylvania

For Provider Use Only

Contact Person at Provider's Office:
_____
Telephone Number: _____

Member ID / Name	Date(s) of Service	Claim Number	Remit Amount

Reason for Refund:	**Type of Refund:**
☐ Payment of Outstanding Credit Balance / AR ☐ Duplicate Payment ☐ Worker's Compensation ☐ Medicare ☐ Other Insurance _____ ☐ Provider Billing Error ☐ Processing Error ☐ Unable to Identify Patient ☐ Multiple Payments (If multiple members are affected, check box and attach a copy of your Statement of Remittance with names highlighted.)	☐ Medical Claim ☐ Capitation ☐ Other _____

Comments: _____
_____
_____
_____

Providing patient information enables us to credit your account in a timely manner. Please return a copy of the Statement of Remittance with this request.

Please submit to: **AmeriHealth Claims Overpayment**
P.O. Box 15075
Newark, NJ 07192-5075

The preferred, more expedient method for handling overpayment/refund issues is through the claims adjudication process in which credits and/or retractions will automatically appear in your next Statement of Remittance. To request these adjustments, or if you have any questions, please call Provider Services at (800) 227-3119 for assistance.

Thank you for your cooperation.