



AMERIHEALTH OVERPAYMENT / REFUND FORM

Date: _____ Provider Number: _____

Provider Name: _____

Provider Address: _____

For Provider Use Only
Contact Person at Provider's Office:
Telephone Number:

Table with 4 columns: Member ID / Name, Date(s) of Service, Claim Number, Remit Amount

Reason for Refund:
Type of Refund:
List of checkboxes for various reasons and refund types.

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 1-800-275-2583 for assistance.

Thank you for your cooperation.