IntegraNet Overpayment Refund Notification Form

For the overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is for an IntegraNet Health check or EFT, please include a completed form specifying the reason for the return of the check.

Provider information	
Provider name/contact:	
Contact number:	Provider ID:
NPI number:	Provider tax ID:
Subscriber ID:	DCN number (Displayed on CCU letter):
Member information	
Member name:	
Member account number:	Date of service:
Total billed charges:	Claim number:
Overpayment information	
Total check amount:	Date overpayment identified:
Date range/time frame the issue(s) occurred:	Specific CPT/HCPCS/DRG code(s) involved with the reimbursement:
Have you performed due diligence to ensure this voluntary refund is isolated only to the identified claim(s)? ☐ Yes ☐ No	
Did you self-identify the overpayment? ☐ Yes ☐ No	
If no, then briefly explain who identified the overpayment and issues or billing codes that were identified.	

Additional claim(s)			
Claim number	**Member name**	**Member account #**	**Date of service**

Reason for refund or check return:

☐ IntegraNet Health letter
☐ Contract rate change
☐ Duplicate payment
☐ Incorrect member
☐ Incorrect provider
☐ Negative balance
☐ Other health insurance/third-party liability
☐ Payment error
☐ Billed in error/adjusted charge
☐ Other: _____

All refund checks should be mailed with a copy of this form to:
IntegraNet Health
Attention: CCU
2900 N Loop W, Ste 700
Houston TX, 77092

Thank you for completing this *Overpayment Refund Notification Form*.

Providers should send written notices contesting requests to the address above. Be sure to identify the portion of the overpayment that is contested and the specific reason(s) for contesting the overpayment.