Virginia Premier Elite
P.O. Box 4250
Richmond, VA 23220
Toll-Free: (877) 739-1370 (TTY:711)
www.elite.vapremier.com

Claim Refund Request Form

Please Check One: Fee for Service Capitation

Provider Name: _____

Provider Number: _____

Member ID#: _____ Claim Filed on: CMS1500 UB 04

Date Sent: _____

Patient Name: _____ Acct Number: _____

Provider Info:

Contact Name: _____ Claim Number(s): _____

Telephone: _____ Referral/Authorization #: _____

Provider Name and Address: _____ Date(s) of Service: _____

_____ Refund Check Date: _____

_____ Refund Check Number: _____

Fax Number: _____ Refund Check Amount: _____

Reason for Request:

COB Charges Billed in Error Duplicate Payment Diagnosis/Procedure Code/Unit Amount Change

Other: _____

Please explain requested action: (Supporting Documentation Required)

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