VirginiaPremier™
Powered by VCU Health

# Provider Refund Form

Virginia Premier Claims:

PO Box 5286
Richmond, VA 23220
Phone (804) 819-5151
Toll Free (800) 727-7536
**Fax Number (804) 819-5174**

Please Check One: ☐ Fee for Service

☐ Capitation ☐ Other _____

Provider Name: _____

Provider Number: _____

Insured's Medicaid ID #: _____

Claim filed on: ☐ HCFA 1500 ☐ UB 92

Patient Name: _____

Date Sent: _____

Acc't Number: _____

**Provider Information:**

Contact Name: _____

Telephone #: _____

Provider Name and Address: _____

_____

_____

Fax Number: _____

Claim Number(s): _____

Referral / Authorization #: _____

Date(s) of Service: _____

Refund Check Date: _____

Refund Check Number: _____

Refund Check Amount: _____

**Reason for Request:**

☐ COB Charges ☐ Billed in Error Diagnosis / Procedure ☐ Duplicate Payment

☐ Code / Unit Amount Change ☐ Other _____

**Please explain requested action: (Supporting Documentation Required)**

_____

_____

_____