Provider Refund Form

Virginia Premier Claims:

PO Box 5286
Richmond, VA 23220 Phone
Phone: 1-804-819-5151
Toll Free: 1-800-727-7536
Fax: 1-804-819-5174

Please Check One: ☐ Fee for Service

☐ Capitation ☐ Other _____

Provider Name: _____

Provider Number: _____

Insured's Medicaid ID #: _____

Patient Name: _____

Claim filed on: ☐ HCFA 1500 ☐ UB 92

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 ☐ Duplicate Payment

☐ Diagnosis / Procedure Code / Unit Amount Change ☐ Other _____

Please explain requested action: (Supporting Documentation Required)

_____

_____

_____