network health

FULL CLAIM RECOUPMENT REQUEST FOR PROVIDERS

This form is to be used for full recoupments only.
Partial recoupments must follow the claim submission policy.

Date requested _____

Provider Name _____ NPI _____ Payee ID _____

Provider's physical address _____

City, state, zip _____

Provider contact person _____

Contact email _____

Requested by _____ Phone with extension _____

Patient name _____ DOB _____

Member # _____ Group # _____

Claim # _____ DOS _____

Amount Billed $ _____

Recoup Amount $ _____

Please mark reason for recoupment

- ☐ Duplicate payment
- ☐ Billed in error (reason) _____
- ☐ Not our patient
- ☐ Incorrect patient
- ☐ Paid incorrect provider
- ☐ Other insurance primary-EOB attached
- ☐ Medicare primary-EOB attached
- ☐ Combined w/charges on another claim
- ☐ Workers' comp paid
- ☐ Received corrected explanation of Medicare benefit
- ☐ 3rd Party liability paid (auto, homeowners, etc.) EOB attached
- ☐ Other _____

Please fax request to Payment Integrity at 920-720-1868