[Your Company Name/Insurance Provider]
[Department Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Provider or Facility Name]
[Attention: Billing Department]
[Address]
[City, State, Zip Code]

RE: REQUEST FOR REFUND - COORDINATION OF BENEFITS OVERPAYMENT

Patient Name: [Patient Name]
Member ID: [Member ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Total Amount Paid: $[Amount Paid]
Requested Refund Amount: $[Refund Amount]

Dear Billing Department,

We are writing to request a refund for an overpayment made on the above-referenced claim. Upon a recent audit of our records and a review of the Coordination of Benefits (COB) information, it has been determined that an overpayment occurred for the following reason:

[Select one or provide details: This plan is secondary to another insurance carrier / The primary carrier has already paid the maximum allowed amount / Duplicate payment received from both primary and secondary carriers].

According to our records, [Name of Primary Insurance] is the primary payer for this patient. As the secondary payer, our liability is limited to the remaining balance after the primary carrier's adjudication, up to our maximum allowable rate.

Please review your records and issue a refund in the amount of $[Refund Amount] within [Number, e.g., 30] days of the date of this letter. Please make the check payable to [Payee Name] and include a copy of this letter or the claim number with your payment to ensure proper credit.

If you have already processed this refund or if you believe this request is in error, please contact our Coordination of Benefits department at [Phone Number] or [Email Address].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name/Signature]
[Title]
[Company Name]