

Date: [Insert Date]

To:

[Provider Name]

[Facility/Practice Name]

[Address Line 1]

[City, State, Zip Code]

RE: NOTICE OF CLAIM OVERPAYMENT AND REFUND REQUEST

Claim Information:

- **Patient Name:** [Insert Patient Name]
- **Member ID:** [Insert Member ID]
- **Claim Number:** [Insert Claim Number]
- **Date(s) of Service:** [Insert Date Range]
- **Total Amount Paid:** \$[Insert Amount]
- **Corrected Amount Due:** \$[Insert Amount]
- **Overpayment Amount Requested:** \$[Insert Amount]

Dear Provider,

Upon a recent audit of the claim identified above, it has been determined that an overpayment was issued. This overpayment occurred due to the following reason:

[Insert Reason: e.g., Duplicate payment, Coordination of benefits, Coding error, Service not covered, or Processing error]

We kindly request a refund of **\$\$[Insert Overpayment Amount]** within [Insert Number, e.g., 30] days of the date of this letter. Please make your check payable to [Insert Payer/Company Name] and include a copy of this notice to ensure proper credit to your account.

Remit Payment To:

[Company Name]

[Department/Attn]

[Address Line 1]

[City, State, Zip Code]

If you believe this overpayment determination is in error, you have the right to appeal this decision. Please submit your written dispute and supporting documentation to the address listed above by [Insert Deadline Date].

If payment is not received within the specified timeframe, we may initiate an offset against future claim payments as permitted by law or contract.

Thank you for your prompt attention to this matter.

Sincerely,

[Sender Name/Department]

[Company Name]

[Phone Number]

[Email Address]