

[Your Company/Insurance Name]
[Department Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]

Date: [Current Date]

RE: NOTICE OF CLAIM OVERPAYMENT AND REFUND REQUEST

Provider Name: [Dentist/Practice Name]
Provider NPI: [NPI Number]
Patient Name: [Patient Name]
Member ID: [Member ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Overpayment Amount: \$[0.00]

Dear Billing Department/Provider,

We are writing to notify you that an audit of the dental claim referenced above has identified an overpayment. Our records indicate that a refund is due for the following reason:

[Reason: e.g., Duplicate payment / Coordination of benefits / Incorrect procedure code / Patient no longer eligible / Payment exceeded contracted rate]

Action Required:

Please review your records and remit the refund amount of \$[0.00] within [Number of Days, e.g., 30] days of the date of this letter. Please make the check payable to [Your Company Name] and include a copy of this letter or the claim remittance advice to ensure the payment is applied correctly.

Send payment to:

[Company Name]
[Attn: Refund Department]
[Address Line 1]
[City, State, Zip Code]

If you disagree with this overpayment determination, you may submit a formal appeal in writing within [Number] days. Please include any supporting documentation or dental records to justify the original payment.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name/Department]
[Your Company Name]