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

[Date]

[Provider or Member Name]
[Address]
[City, State, Zip Code]

RE: Notice of Claim Overpayment and Refund Request

Member Name: [Member Name]
Member ID: [ID Number]
Claim Number: [Claim Number]
Date of Service: [Date]
Amount Paid: $[Amount]
Overpayment Amount: $[Amount]

Dear [Name],

We are writing to inform you that a recent audit of the claim referenced above has identified an overpayment due to Coordination of Benefits (COB).

Based on our records and information received from [Name of Other Carrier], it has been determined that [Our Company] is the **secondary** payer for these services. As a result, the primary insurance carrier should have processed this claim first. Our payment was calculated without the appropriate primary payment information, resulting in an overpayment.

Please review your records and remit a refund in the amount of $[Amount] within [Number] days of the date of this letter. Please include a copy of this notice with your payment to ensure it is applied to the correct account.

Remittance Address:
[Insurance Company Name]
[Refund Department Address]
[City, State, Zip Code]

If you believe this determination is in error, or if you have already submitted the primary Explanation of Benefits (EOB) for our review, please contact our Coordination of Benefits Department at [Phone Number].

Thank you for your cooperation.

Sincerely,

[Sender Name]
[Title]
[Insurance Company Name]