

[Date]

[Pharmacy Name]
[Pharmacy Address]
[City, State, Zip Code]

RE: Notice of Claim Overpayment and Refund Request

Dear Pharmacy Manager / Billing Department,

This letter serves as formal notification that an audit or review of processed claims has identified an overpayment made to your pharmacy for the following transaction(s):

Member Name	Member ID	Date of Service	RX Number	Claim ID	Overpayment Amount
[Member Name]	[ID Number]	[MM/DD/YYYY]	[RX Number]	[Claim Number]	[\$[0.00]]

Reason for Overpayment: [Insert Reason, e.g., Coordination of Benefits, Duplicate Payment, Pricing Error, or Eligibility Change].

Action Required:

Please review your records and remit the total refund amount of **[\$[Total Amount]]** within [Number] days of the date of this letter. Checks should be made payable to [Entity Name] and mailed to the address below:

[Company Name]
Attn: [Department Name/Refunds]
[Mailing Address]
[City, State, Zip Code]

If you prefer to have this amount offset against future pharmacy benefit remittances, or if you believe this overpayment notice is in error, please contact our Provider Relations Department at [Phone Number] or [Email Address] within [Number] business days.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name/Department]
[Company Name]
[Phone Number]