

[Date]

[Provider Name]

[Provider Address]

[City, State, Zip Code]

**RE: Notice of Claim Overpayment and Refund Request**

**Patient Name:** [Patient Name]

**Member ID:** [Member ID Number]

**Claim Number:** [Claim Number]

**Date(s) of Service:** [Date Range]

Dear Billing Department,

This letter is to notify you that the health insurance coverage for the above-referenced patient was retroactively terminated effective [Termination Date]. As a result, the patient was not eligible for benefits at the time the services were rendered.

Due to this retroactive termination, the claim(s) previously paid by [Insurance Company Name] in the amount of \$[Amount Paid] were processed in error. This letter serves as a formal request for a refund of the overpayment.

**Overpayment Details:**

- Total Amount Paid: \$[Amount]
- Reason: Retroactive Termination of Coverage
- Refund Due Date: [Date]

Please remit the total refund amount to the address listed below. Please include a copy of this letter or the claim remittance advice with your payment to ensure the refund is credited correctly.

[Insurance Company/Payer Name]

[Refund Department Address]

[City, State, Zip Code]

If you have already issued a refund for this claim, please disregard this notice. If you have questions regarding this request, please contact our Provider Services Department at [Phone Number].

Sincerely,

[Your Name/Department]

[Company Name]