[Your Company Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Third-Party Payer Name]
[Claims Department Address]
[City, State, Zip Code]

RE: NOTICE OF CLAIM OVERPAYMENT AND REFUND REQUEST

Patient Name: [Patient Name]
Date of Birth: [DOB]
Claim Number: [Claim #]
Policy/Group Number: [Policy #]
Date of Service: [Date of Service]
Overpayment Amount: $[Amount]

Dear Claims Administrator,

This letter serves as formal notification that an overpayment has been identified regarding the claim referenced above. Our records indicate that a payment was issued in error or in excess of the allowed amount for the following reason:

[Insert Reason: e.g., Coordination of benefits, duplicate payment, incorrect fee schedule application, or third-party liability settlement.]

As a result, we are requesting a refund in the amount of **$[Amount]**. Please review your records and process the reimbursement within [Number] days of receipt of this notice.

Please make the check payable to **[Your Company Name]** and mail it to the address listed at the top of this letter. Kindly include a copy of this notice or the remittance advice with your payment to ensure the funds are applied to the correct account.

If you believe this overpayment request is in error or if you require additional documentation, please contact our billing department at [Phone Number] or [Email Address].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name/Signature]
[Your Title]
[Your Department]