

# Unsolicited Overpayment Refund/Notification Form

Please complete this form and include it with your unsolicited refund check so that we can properly apply the check and record the receipt. Make the check payable to UnitedHealthcare and submit it with any supporting documentation.

## Send your check and this form to:

UnitedHealthcare  
 PO Box 101760  
 Atlanta, GA 30392-1760

<b>Provider/Physician/Supplier Name</b>	<b>Contact Person and Phone #</b>		
<b>Address</b>	<b>Check #</b>	<b>Check Date</b>	<b>Check Amount \$</b>
<b>Taxpayer ID # (TIN)</b>	<b>National Provider Identifier (NPI)</b>		

## Unsolicited Refund Information

Please provide the following information for the claim being refunded. For multiple claims, print the attached spreadsheet with a list of all claim numbers involved.

<b>Patient Name</b>	<b>Temporary Member ID</b> (assigned by UnitedHealth Group)
<b>Date of Service</b>	<b>Claim #</b> (that was overpaid)
<b>Claim Amount Refunded \$</b>	
<b>Adjustment Reason Code</b> (select one): <input type="checkbox"/> 01 - Billing/Clerical Error <input type="checkbox"/> 02 - Corrected Date of Service <input type="checkbox"/> 03 - Duplicate <input type="checkbox"/> 04 - Corrected CPT Code <input type="checkbox"/> 05 - Not Our Patient(s) <input type="checkbox"/> 06 - Modifier Added/Removed <input type="checkbox"/> 07 - Billed in Error <input type="checkbox"/> 08 - Insufficient Documentation <input type="checkbox"/> 09 - Patient Enrolled in HMO <input type="checkbox"/> 10 - Services Not Rendered <input type="checkbox"/> 11 - Medical Necessity <input type="checkbox"/> 12 - Non-Credentialed Provider <input type="checkbox"/> 13 - Compliance Audit (Extrapolation Used) <input type="checkbox"/> Other (Please Specify): _____ _____	

<b>Provider Signature:</b>	<b>Date:</b>
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Reimbursement applies to eligible claims, as determined by HRSA (subject to adjustment as may be necessary), for dates of service or admittance delivered on or after February 4, 2020, subject to available funding; see details at [hrsa.gov/coviduninsuredclaim](https://hrsa.gov/coviduninsuredclaim). Terms and conditions will apply. Content subject to change.

This spreadsheet should be used to submit multiple unsolicited refunds for identified overpayments by UnitedHealth Group.

Please supply all available information as noted below to help ensure the proper posting of your check. Additional documentation, such as a Provider Remittance Advice (PRA), is also helpful and should be submitted if available.

Please be specific when completing the Adjustment Reason Code column (codes noted on form above) and make sure your check total equals the Claim Amount Refunded totals identified. Thank you.

Provider TIN	Patient Name	Temporary Member ID	Date of Service	Claim #	Claim Amount Refunded \$	Check #	Adjustment Reason Code

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