Standard Provider Refund Form

ConnectiCare®
VIP Medicare Plans

Please use this form to submit your refund should you receive an overpayment from ConnectiCare.

Send to: ConnectiCare VIP Claims Refund
P.O. Box 416947
Boston, MA 02241-6947

Courier Delivery Address: Bank of America Merrill Lynch
Lockbox Services
Lockbox 416947, Ma5-527-02-07
2 Morrisey Boulevard
Dorchester, MA 02125

Provider name: _____ Date: _____

Provider ConnectiCare ID: _____

Address: _____

_____

Authorized signature:_____ Date: _____

Please check one of the following:

☐ Please deduct this overpayment from future remittance.

☐ I have attached a personal check to refund the overpayment.
Check No.: _____
Amount: _____

☐ I have attached the check to be voided.
Check No.: _____
Amount: _____

Patient's name: _____ ConnectiCare Member ID: _____

Claim number: _____ Date(s)of service: _____

Procedure/service: _____ Total charge: _____

Reason for refund (check one)

☐ Charges billed in error (explain)_____

_____

☐ Duplicate payment

☐ Not our patient

☐ No fault insurance

☐ Paid by other insurance

☐ Workers' compensation

☐ Other (explain)_____

_____

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