



# Provider Refund Submission Form

Complete this form when your office determines an overpayment has been made on one of your patients. It is not necessary to call Customer Service prior to submitting this form. However, if you need assistance completing the form, please contact us. Make sure to fill out the form completely and attach copies of the requested claims that result in overpayment.

Date \_\_\_\_\_ Please check refund type:  Medical  Dental  Vision

Provider Tax ID No.: \_\_\_\_\_  
Provider NPI: \_\_\_\_\_  
Provider name: \_\_\_\_\_  
Provider remit address: \_\_\_\_\_  
\_\_\_\_\_  
Office contact name: \_\_\_\_\_  
Office phone: \_\_\_\_\_  
Office fax: \_\_\_\_\_

Subscriber name: \_\_\_\_\_  
Subscriber identification number: \_\_\_\_\_  
Patient name: \_\_\_\_\_  
Patient date of birth: \_\_\_\_\_  
Date of service: \_\_\_\_\_ Claim number: \_\_\_\_\_  
Billed amount: \$ \_\_\_\_\_ Amount of overpayment: \$ \_\_\_\_\_  
**Method of refund (check one option)**  
 Refund check, Amount \$ \_\_\_\_\_  
*Please enclose your refund check with this form and mail to:*  
ODS  
Unit 21  
P.O. Box 4800  
Portland OR 97208-4800  
 Please deduct on next PDR,  
Amount ODS should take back \$ \_\_\_\_\_  
Authorized signature \_\_\_\_\_  
*(By signing here, you authorize ODS to take a manual deduction on your PDR.)*

COMMENTS:

Medical Customer Service: 503-265-2964 or 888-217-2363      Dental Customer Service: 503-265-2967 or 888-873-1393

**CHECK THE BOX THAT BEST DESCRIBES THE REASON FOR THE REFUND.**

**Corrected claim** (submit with copy of corrected claim)  
 Charges billed in error  
 Paid incorrect provider at this practice  
 Coding change  
 Billed on incorrect patient

**Patient is unknown to this practice** (no corrected billing required)

**Workers Compensation/ Subrogation** (Attach EOB) (Medical claims only)  
Accident date: \_\_\_\_\_

**Duplicate payment**  
Duplicate claim number \_\_\_\_\_

**COB/ODS as Secondary payor**  
 Coinsurance incorrect (attach other carrier EOB)  
 Paid as primary (attach other carrier EOB)

**Accident-related (attach EOB)**  
Date of accident: \_\_\_\_\_  
Please provide details of the accident (what happened and who is responsible etc.) in the comment section.

**Other**  
Please provide details in the comment section.