



A Public Entity

Inland Empire Health Plan

Provider Identified Overpayment Form

Providers may utilize this form when the Provider Business Office has identified an overpayment for a single IEHP member. A copy of this form should accompany the refund payment made to the Inland Empire Health Plan (IEHP).

Provider Name: _____

Provider Phone #: _____

Provider Address: _____

Patient Name: _____ IEHP ID#: _____

Date(s) of Service: _____

IEHP Claim Number(s): _____

Refund Amount: _____ Check #: _____

Reason for Refund (Check all that apply)

Not our Patient

Duplicate Payment

Wrong Procedure Code Billed

Wrong Contract Rate Paid

Prop 56 Overpayment

GEMT Overpayment

Patient has Other Health Coverage (please attach copy of EOB from Other Health Coverage)

Patient has Medicare (please attach copy of EOB from Medicare)

Other (please specify): _____

Please mail your completed form and your refund check to:

IEHP

ATTN: Audit Recovery Department

P.O. Box 4199 Rancho Cucamonga CA 91729-4199

You can establish an active repayment plan by opting to allow IEHP to deduct your overpayment liability from future claims payment until your outstanding overpayment liability balance has been paid in full by signing the below. Return your signed form to the address above or **Fax to (909) 296-3636**.

Authorized by: _____

Title: _____

Date: _____