

Provider Identified Overpayment Form

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

Provider Name:	Provider Phone Number:		
Contact Person:	Phone Address:		

Please select a reason for the refund from the below and enter that reason in the "Reason for Refund" column below.

Not our Patient	Duplicate Payment	Wrong Procedure Code Billed		
Prop 56 Overpayment	GEMT Overpayment	Patient has Other Health Coverage*		
Wrong Contract Rate Paid	Patient has Medicare*	Other (please specify)		

* Please attach a copy of the other health coverage carrier EOB

Members Name	IEHP ID#	Date(s) of Service	IEHP Claim Number(s)	Refund Amount	Check #	Reason for Refund



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Members Name	IEHP ID#	Date(s) of Service	IEHP Claim Number(s)	Refund Amount	Check #	Reason for Refund



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: _____