



# Provider Identified Overpayment Form



This form may be utilized by providers when an overpayment has been identified by the provider business office. A copy of this form should accompany the refund payment made to the Alliance.

Provider Name: \_\_\_\_\_

Provider Billing #: \_\_\_\_\_ Provider Phone #: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient Alliance ID#: \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_

Claim Number(s): \_\_\_\_\_

Refund Amount: \_\_\_\_\_ Check #: \_\_\_\_\_

**Reason for Refund (Check all that apply):**

- ☐ Not our Patient/Wrong Provider
- ☐ Duplicate Payment
- ☐ Wrong Procedure Code
- ☐ Patient has Other Health Coverage (please attach copy of EOB from OHC/CCS)
- ☐ Patient has Medicare (please attach copy of EOB from Medicare)
- ☐ Other (please specify): \_\_\_\_\_

Please enclose a copy of this form with your refund so we can apply the refund to the correct patient account. Please mail refund payable to:

Central California Alliance for Health  
ATTN: Recoveries Administrator  
1600 Green Hills Road, Suite 101  
Scotts Valley, CA 95066-9998

If you are not sending a refund, this form can be emailed or faxed to:

Email: [RecoveriesAdmin@ccah-alliance.org](mailto:RecoveriesAdmin@ccah-alliance.org)  
Fax: 831-430-5871

If you have any questions, please contact the Recoveries Administrator at 831-430-2505.