OptimaHealth

Provider Refund Form

Optima Health Claims:
PO Box 5286
Richmond, VA 23220
Phone: 1-804-819-5151
Toll-free: 1-800-881-2166 (TTY: 711)
Fax: 1-804-819-5174

Insured's Medicaid ID #: _____

Patient Name: _____

Provider Information:

Contact Name: _____

Telephone #: _____

Provider Name and Address: _____

_____

_____

Fax Number: _____

Please Check One: ☐ Fee-for-Service

☐ Capitation ☐ Other _____

Provider Name: _____

Provider Number: _____

Claim filed on: ☐ HCFA 1500 ☐ UB 92

Date Sent: _____

Acc't Number: _____

Claim Number(s): _____

Referral / Authorization #: _____

Date(s) of Service: _____

Refund Check Date: _____

Refund Check Number: _____

Refund Check Amount: _____

Reason for Request:

☐ COB Charges ☐ Billed in Error ☐ Duplicate Payment

☐ Diagnosis / Procedure Code / Unit Amount Change ☐ Other _____

Please explain requested action: (Supporting Documentation Required)

_____

_____

_____