Sentara®
Health Plans

# Provider Refund Form

Sentara Health Plans Provider Refunds:
PO Box 61732
Virginia Beach, VA 23466
Phone: **1-757-687-6307**
Toll-free: **1-800-508-0528 (TTY: 711)**
Fax: **1-833-666-0717**
Email: **provider_refunds@sentara.com**

Insured's ID number: _____ Patient name: _____

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**Provider Information**

Contact name: _____ Telephone number: _____

Provider name and address:

_____

_____

Fax number: _____

Please check one: ☐ Fee-for-service ☐ Capitation ☐ Other

Provider name: _____ Provider number: _____

Claim filed on: ☐ HCFA 1500 Date sent: _____ Account number: _____
☐ UB 92

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Claim number(s): _____ Referral/Authorization number: _____

Date(s) of service: _____ Refund check date: _____

Refund check number: _____ Refund check amount: _____

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**Reason for request:**

☐ COB charges
☐ Billed in error
☐ Duplicate payment
☐ Diagnosis/Procedure code/Unit amount change
☐ Other

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**Please explain requested action: (Supporting documentation required)**

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