Inland Empire Health Plan

REFUND FORM

Provider of Service Information	
Provider Name:	
Provider Address:	
Provider Contact Info:	
Patient Information	
Member Name:	
Member ID:	
Date of Service:	
IEHP Claim Number:	
Overpayment Calculation	
Expected Reimbursement $	
Payments Received by IEHP $	
Refund Amount $	
Reason for Refund	
☐ Incorrect Case Rate	☐ IPA responsibility – EOB attached
☐ Duplicate – RA of duplicate payment attached	☐ Other insurance paid as primary – EOB attached
☐ Services Billed in Error	☐ CCS paid
☐ Overpaid according to contract	☐ Medi-Cal Fee For Service
☐ Other	
Additional Comments	
Enclose a check payable to IEHP, or authorize IEHP to deduct this overpayment from future claims payments by signing this form below.	

Authorized by: _____ Title: _____ Date: _____