Provider refund submission form

Date _____

Please check refund type:

☐ Medical ☐ Dental ☐ Vision

Complete this form when your office determines an overpayment has been made on one of your patients. It is not necessary to call Customer Service prior to submitting this form. However, if you need assistance completing the form, please contact us. Make sure to fill out the form completely and attach copies of the requested claims that result in overpayment.

Section 1: Provider information

Provider tax ID No.	Provider NPI
Provider name	Office contact name
Provider remit address	
Office phone	Office fax

Section 2: Patient information

Subscriber name	Subscriber ID No.
Patient name	Patient date of birth
Date of service	Claim number
Billed amount	Amount of overpayment

Section 3: Method of refund (please select one)

☐ **Refund check** — amount $ _____

Please enclose your refund check with this form and mail to:
Delta Dental
Attn: Accounting
601 SW Second Avenue
Portland, OR 97204

☐ **Please deduct on next PDR** — amount Moda Health should take back $ _____

Authorized signature _____

By signing here, you authorize Moda Health to take a manual deduction on your PDR.

Section 4: Reason for refund (check the box that best describes the reason for the refund)

☐ **Corrected claim** — submit with copy of corrected claim
- ☐ Charges billed in error
- ☐ Paid incorrect provider at this practice
- ☐ Coding change
- ☐ Billed on incorrect patient

☐ **Worker is unknown to this practice** — no corrected billing required

☐ **Workers Compensation/Subrogation (Medical claims only)** — attach EOB

Accident date: _____

☐ **Duplicate payment**

Duplicate claim number: _____

☐ **COB/ODC as Secondary payor**
- ☐ Coinsurance incorrect — attach other carrier EOB
- ☐ Paid as primary — attach other carrier EOB

☐ **Accident-related** — attach EOB and please provide details of the accident (what happened and who is responsible, etc.) in the comment section.

Date of accident: _____

☐ **Other** — please provide details in the comment section

Comments:

Questions? Dental Customer Service at 503-265-2967 or 888-873-1393.

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