

# CHECK REFUND FORM



## Instructions for Completion of this Form:

Please complete and forward to Passport Advantage. This form should accompany every unsolicited/voluntary refund so that receipt of check is properly recorded and applied.

Are there multiple claims? (CHECK ONE)

- YES** (If yes, please list all claim numbers involved, or attach statement of remit. You do not have to submit additional forms.)  
 **NO**

Provider Name: \_\_\_\_\_ Provider ID Number: \_\_\_\_\_

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

Tax ID #: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Amount of Check \$: \_\_\_\_\_ Check #: \_\_\_\_\_ Check Date: \_\_\_\_\_

## Refund Information

For each claim, please provide the following:

Member Name: \_\_\_\_\_ Passport Advantage ID #: \_\_\_\_\_

Reason Code for Claim Adjustment: \_\_\_\_\_ Claim Amount Refunded \$: \_\_\_\_\_

Passport Advantage Claim Number: \_\_\_\_\_

## Reason Codes:

(Select reason code from list below. Use one reason per claim.)

01 – Corrected Date of Service

02 – Duplicate

03 – Corrected CPT Code

04 – Not Our Patient(s)

05 – Modifier Add/Remove

06 – Billed in Error

07 – Primary Group Health Plan Insurance

08 – No Fault Insurance

09 – Insufficient Documentation

10 – Workers Compensation

11 – Services Not Rendered

12 – Medical Necessity

13 – Other-Please Specify

## Please send this form and all checks to:

Passport Advantage

Attn: PAD Overpayment Recovery Unit

P.O. Box 152107

Tampa, FL 33684

If you have questions about this form, please contact the Provider Claims Service Unit (PCSU) at (800) 578-0775.