

# Refund/Deduct Authorization Form



## Section 1 – Payment Information

The following information must be provided when returning an incorrect payment or requesting a deduction. If sending a voluntary refund, be certain to attach your check with this form. Thank you.

_____ Provider Name	_____ Patient Name	
_____ Provider Number	_____ Member Name	
_____/_____/_____ Date of Service	_____ Total Charge	_____ Member Identification Number
_____/_____/_____ Date Paid	_____ Amount Paid	_____/_____/_____ Today's Date

## Section 2 – Request Type

Please check one.

- Refund check enclosed  
Cost Center 830
- Deduction request  
Cost Center 248
- Request refund letter  
Cost Center 248

## Section 3 – Reason for Refund/Deduct

Please provide a detailed explanation of reason for refund/deduct.

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