Inland Empire Health Plan

Provider Identified Overpayment Form

Providers may utilize this form when the Provider Business Office has identified an overpayment for a single IEHP member. A copy of this form should accompany the refund payment made to the Inland Empire Health Plan (IEHP).

Provider Name: ____

Provider Phone #: ____

Provider Address: ____

Patient Name: ______________________ IEHP ID#: _________________

Date(s) of Service: ____

IEHP Claim Number(s): ____

Refund Amount: ____________________ Check #: ____________________

Reason for Refund (Check all that apply)

___ Not our Patient

___ Duplicate Payment

___ Wrong Procedure Code Billed

___ Wrong Contract Rate Paid

___ Prop 56 Overpayment

___ GEMT Overpayment

___ Patient has Other Health Coverage (please attach copy of EOB from Other Health Coverage)

___ Patient has Medicare (please attach copy of EOB from Medicare)

___ Other (please specify): ____________________________________

____

Please mail your completed form and your refund check to:

IEHP

ATTN: Audit Recovery Department

P.O. Box 1800 Rancho Cucamonga CA 91729-1800

You can establish an active repayment plan by opting to allow IEHP to deduct your overpayment liability from future claims payment until your outstanding overpayment liability balance has been paid in full by signing the below. Return your signed form to the address above or **Fax to (909) 296-3636**.

Authorized by: ___________________________________

Title: ____

Date: ____