Provider Identified Overpayment Form

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

Provider Name: _____

Provider Phone Number: _____

Contact Person: _____

Phone Address: _____

Please select a reason for the refund from the below and enter that reason in the "Reason for Refund" column below.

Not our Patient	Duplicate Payment	Wrong Procedure Code Billed
Prop 56 Overpayment	GEMT Overpayment	Patient has Other Health Coverage*
Wrong Contract Rate Paid	Patient has Medicare*	Other (please specify)

❖ ***Please attach a copy of the other health coverage carrier EOB***

Members Name	IEHP ID#	Date(s) of Service	IEHP Claim Number(s)	Refund Amount	Check #	Reason for Refund

Provider Identified Overpayment Form

Members Name	IEHP ID#	Date(s) of Service	IEHP Claim Number(s)	Refund Amount	Check #	Reason for Refund

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: _____