Provider Claim Refund Form

Provider Name & Provider Tax ID #	Member Name
Claim(s)	Member Medicaid ID #
Date(s) of Service	Refund Amount & Check #

Reason for Refund *(please check)*:

- ☐ Claim was paid to wrong provider.
- ☐ Claim was paid on wrong member.
- ☐ Claim was paid on a member that was not eligible at the time of service.
- ☐ Claim paid incorrect rate.
- ☐ Claim was paid for a non-covered service.
- ☐ Claim was paid as primary by Iowa Total Care but member has other insurance as primary. **If above checked: Please submit the EOB/EOP of the primary insurance payment.**
- ☐ Claim was paid twice; this is a duplicate payment.
- ☐ Other *(please explain below)*:

_____

_____

_____

Requestor Name: _____

Requestor Phone Number: _____Date of Request: _____

Please mail completed form(s) and all related documentation [e.g., EOP(s)], to:

Iowa Total Care
P.O. Box 958092
St. Louis, MO 63195-8092