HRSA
Health Resources & Services Administration

Updated 02/2023

Unsolicited Overpayment Refund/Notification Form

Please complete this form and include it with your unsolicited refund check so that we can properly apply the check and record the receipt. Make the check payable to UnitedHealthcare and submit it with any supporting documentation.

Send your check and this form to:

UnitedHealthcare
PO Box 101760
Atlanta, GA 30392-1760

Provider/Physician/Supplier Name	**Contact Person and Phone #**		
Address	**Check #**	**Check Date**	**Check Amount $**
Taxpayer ID # (TIN)	**National Provider Identifier (NPI)**		

Unsolicited Refund Information

Please provide the following information for the claim being refunded. For multiple claims, print the attached spreadsheet with a list of all claim numbers involved.

Patient Name	**Temporary Member ID** (assigned by UnitedHealth Group)
Date of Service	**Claim #** (that was overpaid)
Claim Amount Refunded $	

Adjustment Reason Code (select one):

- ☐ 01 - Billing/Clerical Error
- ☐ 02 - Corrected Date of Service
- ☐ 03 - Duplicate
- ☐ 04 - Corrected CPT Code
- ☐ 05 - Not Our Patient(s)
- ☐ 06 - Modifier Added/Removed
- ☐ 07 - Billed in Error
- ☐ 08 - Insufficient Documentation
- ☐ 09 - Patient Enrolled in Health Care Coverage
- ☐ 10 - Services Not Rendered
- ☐ 11 - Medical Necessity
- ☐ 12 - Non-Credentialed Provider
- ☐ 13 - Compliance Audit
- ☐ Other (Please Specify): _____

_____

Provider Signature:	**Date**:

Reimbursement applies to eligible claims, as determined by HRSA (subject to adjustment as may be necessary), for dates of service or admittance delivered on or after February 4, 2020, for testing or treatment claims, and on or after December 14, 2020, for vaccine administration claims, subject to available funding; see details at hrsa.gov/coviduninsuredclaim. Terms and conditions will apply. Content subject to change.

This spreadsheet should be used to submit multiple unsolicited refunds for identified overpayments by UnitedHealth Group.

Please supply all available information as noted below to help ensure the proper posting of your check. Additional documentation, such as a Provider Remittance Advice (PRA), is also helpful and should be submitted if available.

Please be specific when completing the Adjustment Reason Code column (codes noted on form above) and make sure your check total equals the Claim Amount Refunded totals identified. Thank you.

Provider TIN	Patient Name	Temporary Member ID	Date of Service	Claim #	Claim Amount Refunded $	Check #	Adjustment Reason Code

Reimbursement applies to eligible claims, as determined by HRSA (subject to adjustment as may be necessary), for dates of service or admittance delivered on or after February 4, 2020, for testing or treatment claims, and on or after December 14, 2020, for vaccine administration claims, subject to available funding; see details at hrsa.gov/coviduninsuredclaim. Terms and conditions will apply. Content subject to change.