HRSA
Health Resources & Services Administration

Updated 07/2023

Unsolicited Overpayment Refund/Notification Form

Please complete this form and include it with a list of all applicable details for the claim/s being refunded as described below so that we can properly apply your refund check and record the receipt.

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

Refund Information

Please provide the following information for the claim/s being refunded. For multiple claims, print the attached spreadsheet or *download this Excel template* to list all applicable claim details for the claims being refunded. Completed forms, claim details, and any supporting documentation should be emailed to tracr_room@uhc.com, or mailed to UnitedHealthcare, PO Box 101760, Atlanta, GA 30392-1760.

If you are emailing this form and claim details:

- Include your refund check number, as well as the dollar amount of the check, in the subject line.
- Password protect this form and your Excel template. Email both the form and the Excel template to tracr_room@uhc.com.
- Email your password to these documents separately to cashmgt@optum.com using the same subject line.
- Spreadsheets exceeding 20MB should be split and emailed separately with the same subject line.

Refund checks should be made out to UnitedHealthcare and mailed to UnitedHealthcare, PO Box 101760, Atlanta, GA 30392-1760.

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 list multiple claim details for unsolicited overpayment returns.

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.

Provider TIN	Patient Name	Temporary Member ID	Date of Service	Claim #	Claim Amount Refunded $	Payment #	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.