PeakHealth

PROVIDER SELF-AUDIT NOTIFICATION/OVERPAYMENT REFUND FORM

Federal and state regulations require providers to routinely audit claims for overpayments. Peak Health also encourages providers to voluntarily come forward and disclose overpayments or improper payments. Upon identifying the overpayments, providers must notify Peak Health in writing and submit the overpayment within **60 days** after the date on which the overpayment was identified.

Providers can download the form, complete each field and print. While not required, this form will assist Peak Health in processing your refund/overpayment timely and accurately. If you include a check, please make it payable to Peak Health and submit it with this form and any supporting documentation.

Send completed form and supporting documentation to one of the following:

Mail to:
Peak Health
Attention: Payment Integrity
1085 Van Voorhis Road, Suite 300
Morgantown, WV 26505

Email: PaymentIntegrity@Peakhealth.org

Fax: **(304) 285-0395**

Provider/Physician/Vendor Name:	**Address:**

National Provider Identifier (NPI) Number:	**Tax ID Number:**

Contact Person Name:	**Phone Number:**

Type of Refund: (please select one) ☐ **Retraction** ☐ **Check**

Refund Information: Please provide the following information for a single claim. For multiple claims please complete the **Overpayment – Multiple Refunds Request** form.

Patient Name:				**Peak Health Claim Number:**	
Date of Service:		Subscriber ID Number:		Refund Amount $:	

Overpayment Reason Code Key (use 1 reason per claim)

☐ 01 – COB: Please provide other carrier name and subscriber ID, and attach EOB:

☐ 02 – Provider Self-Audit
☐ 03 – Modifier added/removed
☐ 04 – Corrected date of service
☐ 05 – Billed in error
☐ 06 – Duplicate/Multiple payments
☐ 07 – Corrected CPT code
☐ 08 – Billing/clerical error
☐ 09 – Services not rendered
☐ 10 – Other (*please describe*)
_____

For self-audits: If a specific patient or claim amount data is not available for the claim(s) because you are using statistical sampling, please list the methodology and formula you used to determine amount and reason for overpayment.

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PROVIDER SELF-AUDIT NOTIFICATION/OVERPAYMENT REFUND FORM (CONT)

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Overpayment — Multiple Refunds Request

Use this spreadsheet to submit multiple refunds for identified overpayment. Print this form as many times as needed to include all submitted claims.

Please supply all available information to help ensure a proper refund. Additional documentation, such as Remittance Advice, and other insurance Explanation of Benefits (EOB) is also helpful.

Please be specific when completing the reason for overpayment column and make sure your check total equals the claim totals identified.

Overpayment reason code key (use 1 reason per claim)

☐ 01 – COB: Please provide other carrier name, subscriber ID and attach EOB:

☐ 02 – Provider Self-Audit
☐ 03 – Modifier added/removed
☐ 04 – Corrected date of service
☐ 05 – Billed in error
☐ 06 – Duplicate
☐ 07 – Corrected CPT code
☐ 08 – Billing/clerical error
☐ 09 – Services not rendered
☐ 10 – Other (*please describe*)

Member First Name	Member Last Name	Member ID	Date of Service	Claim Number	Overpayment Reason code	Refund Amount $