Refund/Offset Request Form

Please complete this form and include it with your refund so that we can properly apply the check and record the receipt. If a check is included with this correspondence, please make it payable to Health Plan of San Joaquin and submit it with any supporting documentation.

Please select one (by checking the appropriate box):

- ☐ Immediate Recoupment of Single overpayment (one time offset)
  Reference Tracking Number: _____
- ☐ Immediate Recoupment of Current and All Future Overpayments
- ☐ Refund Check Attached

Provider/Physician/Supplier Name	**Contact Person and Phone #**
Physical Address	**Check #** **Check Date**
Tax ID # **NPI #**	**Check Amount $**

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	**Health Plan of San Joaquin Claim #**
Date of Service	**Member ID #**
Claim Refund Amount $	**Refund Reason Code- One Reason Per Claim**

Reason Codes:	Reason Codes:
Billing/Clerical Error – 01	Insufficient Documentation – 08
Corrected Date of Service – 02	Patient has Other Insurance – 09
Duplicate - 03	Services Not Rendered – 10
Corrected CPT Code – 04	Medical Necessity – 11
Not Our Patient(s) – 05	Non-Credentialed provider – 12
Modifier Added/Removed – 06	Other (Please Specify):
Billed in Error - 07	

Please mail Completed form, check, and a copy of the initial HPSJ Recovery Request letter (if applicable) to:

Health Plan of San Joaquin
Attn: Claims Recovery
7751 S. Manthey Rd
French Camp, CA 95231

Printed Name of Requestor:	
Signature of Requestor:	**Date:**