



Payment Refund Notification

This refund notification pertains to:

Patient Name: _____

Patient ID number: _____

Date of Service: _____

Claim Number: _____

Enclosed is Check Number _____ for \$ _____.

Reason for refund (please check all that apply):

_____ Duplicate payment due to:

_____ Other insurance paid as primary (attach primary carrier's EOB)

_____ Claim previously paid on _____ (Date paid)

_____ Other: _____

_____ Not our patient

_____ Service not performed

_____ Services billed in error

_____ Other: _____

Please send this completed form with your refund check and copy of the original remittance advice to:

**Mercy Health Plans/Premier Benefits, Inc.
ATTN: Adjustment Unit
PO Box 4568
Springfield, MO 65808-4568**