

REFUND SUBMISSION FORM-MEDICAID

Please attach this completed form to your refund check. Include a copy of the Explanation of Payment (EOP), and mail to the following address:

RightCare from Scott & White Health Plan
 PO Box 841476
 Dallas, Texas 75284-1476

Date:	Provider Name:
Address:	Provider Contact Name:
Provider Contact #:	E-Mail:
Member Name:	Member Number:
Claim Number:	Date(s) of Service:
Check Number:	Check Amount:
Check Date:	

Reason for Refund:

- Not our member
- Billed in error
- Wrong provider and/or affiliation
- Services not rendered
- Third party liability determined
- Other coverage paid as primary (refund entire amount and re-submit claim with primary EOB)
- Other _____
