



Provider Refund Form

Virginia Premier Claims:

PO Box 5286
Richmond, VA 23220
Phone (804) 819-5151
Toll Free (800) 727-7536
Fax Number (804) 819-5174

Insured's Medicaid ID #: _____

Patient Name: _____

Provider Information:

Contact Name: _____

Telephone #: _____

Provider Name and Address: _____

Fax Number: _____

Please Check One: ☐ Fee for Service

☐ Capitation ☐ Other _____

Provider Name: _____

Provider Number: _____

Claim filed on: ☐ HCFA 1500 ☐ UB 92

Date Sent: _____

Acc't Number: _____

Claim Number(s): _____

Referral / Authorization #: _____

Date(s) of Service: _____

Refund Check Date: _____

Refund Check Number: _____

Refund Check Amount: _____

Reason for Request:

☐ COB ☐ Charges Billed in Error ☐ Duplicate Payment

☐ Diagnosis / Procedure Code / Unit Amount Change ☐ Other _____

Please explain requested action: (Supporting Documentation Required)
