



Provider Overpayment Form

Please complete the entire form. We can accept a maximum of 10 claims per form under the same check number.

If you are submitting more than 10 claims under the same check number, complete one form and provide a spreadsheet listing all claims. Upload the completed form and all applicable claims to our Provider Portal or mail to:

Jefferson Health Plans/Health Partners Plans, Inc.
Attn: Finance – Cash Receipts
1101 Market Street, Suite 3000
Philadelphia PA 19107

Provider/Health System Name: _____ Date: _____

Address - City, State, ZIP: _____

Check #: _____

Provider NPI: _____ Tax ID: _____

Provider Name: _____

Claim(s) #: _____

Claim(s) Date of Service: _____

Total Charge Billed on Claim(s): _____

Reason for return (please check all that apply):

- Claim overpayment
- Billing error
- Duplicate payment (provide EOB of both claims)
- Other coverage (Primary, Auto, Workmen's Compensation). Please submit other coverage EOB or Denial Letter
- Invalid provider paid/incorrect vendor
- Provider retraction request: (Please provide specific reason)

Health Partners Plans, Inc. (HPP), uses Jefferson Health Plans as the marketing name for some of its lines of business. Current lines of business are: Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans Medicare Advantage, Health Partners Plans Medicaid, and Health Partners Plans CHIP. If product specific, communications will specify the line of business within the content of the message.