Jefferson Health Plans

Provider Overpayment Form

Please fill out the entire form. Jefferson Health Plans 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. Please notify your Provider Relations Representative of the large overpayment request.

Send the completed form and all applicable claims to:

Jefferson Health Plans
Attn: Finance-Cash Receipts
901 Market Street, Suite 500
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.
- ☐ Invalid provider paid/incorrect vendor
- ☐ Provider retraction request: (please provide specific reason)