Refund Form

Instructions for Providers: Gateway cannot accept verbal requests to retract claim(s) overpayments. Providers may complete and submit a Refund Form or a letter that contains all of the information requested on this form.

This form, together with all supporting materials relevant to the claim(s) reversal request being made including but not limited to EOB from other insurance carriers and your refund check should be mailed to:

PNC BANK, c/o GATEWAY HEALTH PAYMENTS/REFUNDS, Lock Box #645171, 500 1st Avenue, Pittsburgh, PA 15219.

PLEASE COMPLETE

Date_____ Group Name_____ Group Number_____

Address_____ Phone Number _____

Practitioner Name_____ Individual Provider Number_____

Vendor Name_____ Tax Identification Number _____

Contact Person at Provider's Office_____ Phone Number_____

E-mail Address_____

Member/Claim Information

Name	Gateway ID #	DOS	Claim Number	Refund Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(Please use a separate sheet for additional Member/Claim Information)

Reason for Refund:

- Payment of Outstanding Credit Balance AR
- Duplicate Payment
- Medicare
- Other Insurance_____
- Provider Billing Error
- Unable to Identify Patient
- Multiple Payments (If multiple members are affected, check box and attach a copy of your Remit with names highlighted)

COMMENT: _____

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