HRSA
Health Resources & Services Administration

Unsolicited Overpayment Refund/Notification Form

Please complete this form and include it with your unsolicited refund check so that we can properly apply the check and record the receipt. Make the check payable to HRSA COVID-19 CAF and submit it with any supporting documentation.

Send your check and this form to:

Provider Relief Bureau
Coverage Assistance Fund
Health Resources and Services Administration
5600 Fishers Lane
Mail Hub 9N34
Rockville, MD 20857

Provider/Physician/Supplier Name	Contact Person and Phone #		
Address	Refund Check #	Check Date	Check Amount $
Taxpayer ID # (TIN)	National Provider Identifier (NPI)		

Unsolicited Refund Information

Please provide the following information for the claim being refunded. For multiple claims, print the attached spreadsheet with a list of all claim numbers involved.

Patient Name	Patient Date of Birth
Date of Service	Claim # (that was overpaid)
Claim Amount Refunded $	

Adjustment Reason Code (select one):

- ☐ 01 - Billing/Clerical Error
- ☐ 02 - Corrected Date of Service
- ☐ 03 - Duplicate
- ☐ 04 - Corrected CPT Code
- ☐ 05 - Not Our Patient(s)
- ☐ 06 - Modifier Added/Removed
- ☐ 07 - Billed in Error
- ☐ 08 - Insufficient Documentation
- ☐ 09 - Patient Enrolled in HMO
- ☐ 10 - Services Not Rendered
- ☐ 11 - Medical Necessity
- ☐ 12 - Non-Credentialed Provider
- ☐ 13 - Compliance Audit (Extrapolation Used)

Other (Please Specify): _____

_____

Provider Signature:	Date:

Reimbursement applies to eligible claims, as determined by HRSA (subject to adjustment as may be necessary), for dates of service or admittance delivered on or after December 14, 2020, subject to available funding; see details at hrsa.gov/provider-relief/about/covid-19-coverage-assistance. Terms and conditions will apply. Content subject to change.

This spreadsheet should be used to submit multiple unsolicited refunds for identified overpayments.

Please supply all available information as noted below to help ensure the proper posting of your check.

Please be specific when completing the Adjustment Reason Code column (codes noted on form above) and make sure your refund check total equals the Claim Amount Refunded total identified above. Thank you.

Provider TIN	Patient Name	Patient Date of Birth	Date of Service	Claim #	Claim Amount Refunded $	Original CAF Check #	Adjustment Reason Code

Reimbursement applies to eligible claims, as determined by HRSA (subject to adjustment as may be necessary), for dates of service or admittance delivered on or after December 14, 2020, subject to available funding; see details at hrsa.gov/provider-relief/about/covid-19-coverage-assistance. Terms and conditions will apply. Content subject to change.