Provider Overpayment Refund Request Form

Instructions: Please complete this form when submitting a refund of an overpayment to SCAN Health Plan. All information below is required for the refund to be processed correctly. For partial refund, indicate the amount included on the check. Failure to complete and return your overpayment amount **within 30 calendar days** will result in SCAN automatically recouping the amount from future payments (contracted providers only).
Note: Fields with an * are required.

Mail check payment, this completed form, the Overpayment Notice and any other documentation to:

SCAN Health Plan
3800 Kilroy Airport Way, Suite 100
Long Beach, CA 90801

For questions, please email Claims Recovery Unit at: claimsrecoveryunit@scanhealthplan.com

Claim(s) Information:

Member ID#	Member First Name	Member Last Name	Date of Service	Claim # (found on notice or RA)	Claim Line # (if for partial claim)	Billed Amount	Over-payment Amount	Full or Partial Refund?

**If additional space is needed, please submit a spreadsheet with additional information*

Provider Information:

Provider Name*:
Provider Address:
City, State, Zip:
Phone #*:
(xxx) xxx-xxxx

Today's Date*:
(MM/DD/YYYY)
Tax ID #*:
NPI #:

Provider Contact Information:

Provider Contact Name:*
Organization (if other than Provider Office):
Email Address:
Phone #:
Preferred Method of Contact:

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