Provider Recoupment Request Form

Important: Providers should confirm payment was made by SCAN and not a delegate.
THIS FORM IS ONLY FOR SCAN ISSUED PAYMENTS.

Instructions: Please complete this form to initiate an immediate recoupment/offset of an identified overpayment of a SCAN claim **within 15 days** of overpayment identification/notice. The recoupment/offset will continue until the overpayment is recouped in full. All information below is required for offset initiation.

Submit this form to: claimsrecoveryunit@scanhealthplan.com or send email for additional options.

Immediate Recoupment? ☐ Note: Must be submitted no later than 16 days from the date of the notice.

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: