Recoupment Request Form

Instructions

Please complete the following fields as thoroughly as possible:

- Patient Account Number
- Patient's Name (This will not necessarily be the same as the member).*
- Member's Name (This will be the name of the policy holder).
- Member ID Number (This can be found on your remittance advice or the member's insurance card).*
- Provider ID number (This is your TIN or SS number plus the two digit suffix that is assigned to the provider and can be found on the remittance advice).
- Claim Number (This can be found on the remittance advice)
- First Date of Service (The first date that services were performed).*
- Total Billed Amount (This is the entire billed amount of the claim).*
- Paid Date (This will be the date of the remittance advice).

*If the claim number is not available this information is required.

Please check one of the following:

- **COB** - If the claim has been paid as primary and there is another insurance company that should be primary please attach the other insurance company's explanation of benefits (EOB) so UnitedHealthcare can reprocess the claim as secondary. Attach an EOB if applicable.
- **Worker's Compensation** - If the claim has been paid by a worker's compensation company, please attach any pertinent information that is available.
- **Subrogation** - If the claim has been paid by another carrier for subrogation, please attach any pertinent information that is available.
- **Claim Billed in Error** - If the entire claim was billed in error or voided.
- **Other** - Please describe in detail the reason for the recoupment request in the description field. **Chose only if other fields do not fit description of request.**
- **Description Field** - Please provide as much detail for the reason of the requested recoupment.

Please mail form and all attachments to: UnitedHealthcare, P.O. Box 5230, Kingston, NY 12402-5230

UnitedHealthcare
A UnitedHealth Group Company

UnitedHealthcare
P.O. Box 5230
Kingston, NY 12402-5230
Phone 800/747-1446

RECOUPMENT REQUEST FORM

Please attach this form to the front of any supporting documentation.

To check on status of recoupment request please call 800/747-1446

Please allow 15 business days to receive recoupment request before checking on status.

For UnitedHealthcare Office Use Only

Patient Account Number	Patient Name	Member Name
Member ID Number	**Provider ID Number**	**Claim Number**
First Date of Service	**Total Billed Amount**	**Paid Date**

Please select one of the following:

- ☐ COB - attach EOB if applicable
- ☐ Worker's Compensation
- ☐ Subrogation
- ☐ Claim Billed in Error
- ☐ Other

Please provide a complete description of recoupment request.