

Provider Self Audits/Overpayments Form

Instructions for Providers: Highmark Health Options (HHO) cannot accept verbal requests to retract claim(s) overpayments. Providers may complete and submit this form for any self-identified overpayments to the HHO Payment Integrity Department.

PLEASE COMPLETE ALL SECTIONS

I. Provider Information

Date _____ Practice Name _____ Provider Number _____
 Practitioner Name _____ Phone Number _____
 Tax Identification Number _____ NPI Number _____
 Contact Person at Provider's Office _____
 Contact Phone Number _____ Contact E-mail Address _____

II. Self-Audit / Overpayment Information

A. Reason for Refund:

(please check one)

Identified through Audit / Review _____
 Duplicate Payment Identified by Provider _____
 Provider Billing Error _____
 Multiple Payments Identified by Provider _____
 Secondary Health Insurance Identified _____

B. Type of Refund:

(please check one)

Retraction Requested _____
(Claims less than 2 years old)
 Check Provided _____
(Claims more than 2 years old)

C. Other Information:

Period of Claims (based on dates of service): _____
 Detailed Description of Overpayment: _____

Mail To:

Highmark Health Options
Attention Payment Integrity Department
 Four Gateway Center
 444 Liberty Avenue, Suite 2100
 Pittsburgh, PA 15222-1222

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

Member Name	HHO ID #	DOS	Claim Number	Refund Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

IV. Other Required Information (as necessary for Provider Self Audits)

Extrapolation Used? _____
 Extrapolation Method & Calculation: _____

** If a listing of claims is not provided, HHO cannot guarantee that the claims will not be included in separate audits, for the same reason.*