



Overpayment Recovery Form

Please mail your refund check, this form and any other required documentation to CareSource at the address below.

Completion of this form in its entirety is required in order to assist with accurate and timely reprocessing of your claims. Include any required documentation with your submission. Do not use this form for submission of Appeals or Correspondence. Thank You!

CareSource
230 N. Main Street
Dayton OH, 45402

Claim Number	Member ID	Date of Service	Amount of Overpayment	Claim Paid Amount	Reason for Refund
123456789XX00	1234567890	00/00/0000	\$50000.00	\$50000.00	Coordination of Benefits

Provider Information	
Provider Name	
Provider Tax ID	
Provider NPI	
Remittance Address	
Service Address	
Alternate Remit Address (if different than Provider Remit)	
Contact Name	
Contact Phone	