HAP CareSource™

Overpayment Recovery Form

Please mail this form and any other required documentation to HAP CareSource™ at the address below.

HAP CARESOURCE
Attention: Claim Recovery Department
P.O. Box 632400
Cincinnati, OH 45263-2400

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 the following:

- Submission of Appeals or Correspondence
- Sending payment

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	