Overpayment Recovery Form

Complete this form in its entirety and include any required documentation with your submission. We need this information to assist with accurate and timely reprocessing of your claims.

Do not use this form for the following:

- Submission of Appeals or Correspondence
- Sending payment

Common Ground Healthcare Cooperative
ATTN: Claim Recovery Department
P.O. Box 1394
Dayton, Ohio 45401

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	Coding error

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	