HAP CareSource™

Claim Recovery Refund Check Form

Please mail your refund check, this form and any other required documentation to HAP CareSource™ MI Coordinated Health (HMO D-SNP at the address below.

HAP CareSource
P.O. Box 632128
Cincinnati, OH 45263-2128

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

Claim and Check Information		
Check Enclosed	○ Yes	○ No
Check Number		
Check Amount		
Total Number of Claims		

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

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