Parkland
Community Health Plan

Parkland Community Health Plan Refund Information Form

To refund a Parkland Community Health Plan overpayment, complete this form and attach the refund check. Make the refund check payable to Parkland Community Health Plan and include a copy of the corresponding PCHP remittance that shows the remitted payment. Mail the completed form, the refund check, and the remittance to the PCHP-Financial Department at the following address:

Parkland Community Health Plan
Attn: Refunds
PO Box 560307
Dallas, TX 75356

A. Provider Information		
Provider Name (please print):		
NPI:	Taxonomy:	Benefit Code:
Street Address:		
City:	State:	ZIP:
Contact Name (please print):		
Telephone Number with Extension:		
E-mail Address:		
B. Claim Information		
Apply refund to claim ICN number		
Patient's Name:	Patient's PCHP ID Number:	
Date(s) of Service (DOS):		
C. Reason for the Refund (Choose One)		
☐ PCHP audit identified overpayment - Please include recoupment letter	☐ Other Insurance paid $ _____ on this claim. **Instructions:** If the submitted refund is because of another insurance payment, attach the other insurance Explanation of Benefits [EOB] document that shows the payment. If no EOB is available, complete the following:	
☐ Duplicate Medicaid payment		
☐ Claim paid on wrong provider's Medicaid NPI/API		
☐ Patient's Medicare eligibility		
☐ Credit balance refund (describe in detail):		
☐ Claim paid on wrong patient's Medicaid ID number	Insurance Co. Name:	
☐ Above named person is not our patient	Address:	
☐ Other refund reason (describe in detail):	Telephone Number:	
Billing Error / Service was not rendered as billed Do not refund. Please submit a corrected claim	Policy Number:	
	Telephone Number:	
	Effective Date:	
	Termination Date:	
Provider Signature (stamped signatures not accepted):		
Date:		