Provider Identified Overpayment Form

This form should accompany any refund payment made to CalOptima, when an overpayment has been identified by your business office, in order to apply the refund to the correct member account.

Provider Name:	
Provider Billing Number:	
Provider Phone Number:	
Provider Address:	
Member Name:	
Member CIN Number:	
Date(s) of Service:	
Claim Number(s):	
Refund Amount:	
Check Number:	

Important: Reason for Refund (Check all that apply)

- ☐ Not our Patient/Wrong Provider
- ☐ Duplicate Payment
- ☐ Wrong Procedure Code (Please attach corrected claim)
- ☐ Patient has Other Health Coverage (OHC) (please attach copy of OHC Explanation of Benefits [EOB])
- ☐ Patient has Medicare (please attach copy of Medicare EOB)
- ☐ Other (please specify): _____

Please enclose a copy of this form with your refund so we can apply the refund to the correct patient account. Please mail refund payable to:

CalOptima
Attn: Claims Recovery Department
P.O. Box 11037
Orange, CA 92856