

Molina Healthcare RETURN OF OVERPAYMENT FORM

ovider name:			
ovider tax identification nur	nber:		
ovider contact person:			
ovider phone number:			
ease fill out the form below	with all applicable in	formation.	
Molina claim number	Molina check number	Amount refunded to Molina	Provider check number (if applicable)
eason the payment is being	returned to Molina F	lealthcare (check one):	
☐ Claims are for patients	not affiliated with th	is office	
☐ Member has primary i	nsurance and claim w	as paid as primary	
☐ Claim was overpaid du	ie to a billing error (pl	ease send corrected claim i	f needed)
_ ,			, , , , , , , , , , , , , , , , , , , ,
☐ Other (please explain)			

Please see next page for remittance address.

Send claim overpayment checks via regular mail to:

Molina Healthcare Medicaid Attn: Recoveries Lockbox 401 Market Street Box 780192 Philadelphia, PA 19178-0192

Send claim overpayment checks via overnight mail to:

Lockbox # 780192 Molina Healthcare Medicaid Attn: Recoveries Lockbox MAC Y1372-045 401 Market Street Philadelphia, PA 19106