Return of Overpayment

☐ **Medicaid** ☐ **Medicare** ☐ **Marketplace** ☐ **MyCare Ohio**

Date: _____

Provider Name: _____

Provider Tax Identification Number: _____

Provider Contact Person: _____

Provider Phone Number: _____

Please fill out the form below with all applicable information.

Molina Claim Number	Molina Check Number	Amount Refunded to Molina	Provider Check Number (if applicable)

Reason the payment is being returned to Molina Healthcare (check one):

☐ Claims are for patients not affiliated with this office.

☐ Member has primary insurance and claim was paid as primary.

☐ Claim was overpaid due to a billing error (please send corrected claim if needed).

☐ Other (please explain) _____

_____

_____

_____

Please direct payment and any correspondence to:
Molina Healthcare of Ohio, Dept. 781661, P.O. Box 78000, Detroit, MI 48278-1661

If returning a Molina Healthcare check only, please send to:
Molina Healthcare of Ohio, P.O. Box 349020, Columbus, OH 43234

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