



Physician and Facility Claims Refund Form

Providers, facilities, and other ancillary care professionals should complete this form to submit a refund.

Please attach this completed form to your refund check made payable to New Mexico Health Connections. Enclose a copy of the NMHC Explanation of Payment and mail to the following address:

New Mexico Health Connections
 Attention: Finance
 P.O. Box 36719
 Albuquerque, NM 87176

PROVIDER/GROUP/FACILITY INFORMATION			
Refunding Physician/Group/Facility Name:			Date:
Provider TIN:	Provider NPI:	Taxonomy:	
Contact Name:		Phone Number:	
Fax Number:		Email Address:	
Billing Address:			
City:		State:	Zip Code:
MEMBER INFORMATION			
Last Name:		First Name:	
Date of Birth:		ID Number:	
CLAIM INFORMATION			
<input type="checkbox"/> Provider	<input type="checkbox"/> Facility	<input type="checkbox"/> Ancillary Health Care Professional (DME, lab, etc.)	
Claim Number:		Date of Service:	
Billed Amount:		Paid Amount:	
Reason: <input type="checkbox"/> Provider not affiliated w/group/facility <input type="checkbox"/> Above-named person is not our patient <input type="checkbox"/> Duplicate payment <input type="checkbox"/> Billing error <input type="checkbox"/> Service was not rendered as billed <input type="checkbox"/> Primary insurance adjusted payment <input type="checkbox"/> Patient is Medicaid-eligible <input type="checkbox"/> Patient is Medicare-eligible <input type="checkbox"/> Other; please enter reason in box below			
Other:			
*If another insurance paid as primary on claim, please attached primary Explanation of Payment (EOP). If no EOP is available, please complete the following below:			
Insurance Company Name:			Telephone Number:
Member Policy Number:			