Select Health of South Carolina | Healthy Connections

Provider Refund Claim Form

In an effort to reduce the administrative burden on our providers, we have streamlined our refund process. Please complete this Provider Refund Claim Form in its entirety. The information provided on this form will enable us to credit your account in a timely manner. If your refund contains more than one claim, please complete the attached form or attach your own file. Thank you for your cooperation.

To return overpaid funds with a check, this form and the refund check should be mailed to:

Select Health of South Carolina
Attn: Claims Repayment Research Unit
P.O. Box 7120
London, KY 40742

To have payment recouped from future payments, mail the form only to:

Select Health of South Carolina
Cost Containment Department
P.O. Box 7320
London, KY 40742

Provider Information

Date:	Provider name:
NPI:	TIN:
Provider address:	
Office contact:	Phone number:

Member Information

Member Name	ID Number	Date of Service	Claim Number	Refund Amount

Please note: If your refund contains more than one claim, please use the attached form (page 2) or attach your own file.

Type of Refund

☐ Medical overpayment	☐ Capitation
Other:	

Reason for Refund

☐ Other insurance. (Attach primary Explanation of Benefits.)	☐ Subrogation
☐ Duplicate payment	☐ Claim was processed under the incorrect provider
☐ Incorrect provider cashed check	☐ Not our check
☐ Billing error	☐ Contract change/fee schedule update
☐ Eligibility	☐ Recovery project. (Please include project letter.)
☐ Bonus payment	☐ Return supplies (durable medical equipment)

Other (Please provide details. Overpayment is not a valid reason.)

Additional claim form

If your refund contains more than one claim, please complete the attached form or attach your own file

Member Name	ID Number	Date of Service	Claim Number	Refund Amount	Reason for Refund
					Duplicate payment
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