REFUND SUBMISSION FORM-COMMERCIAL/MEDICARE

Please attach this completed form to your refund check. Include a copy of the Explanation of Payment (EOP), and mail to the following address:

Scott and White Health Plan
Attn: Claims Department
PO Box 840523
Dallas, TX 75284-0523

Date:	Provider Name:
Address:	Provider Contact Name:
Provider Contact #:	E-Mail:
Member Name:	Member Number:
Claim Number:	Date(s) of Service:
Check Number:	Check Amount:
Check Date:	

Reason for Refund:

- ☐ Not our member
- ☐ Billed in error
- ☐ Wrong provider and/or affiliation
- ☐ Services not rendered
- ☐ Third party liability determined
- ☐ Other coverage paid as primary (refund entire amount and re-submit claim with primary EOB)
- ☐ Other _____

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