Recoupment Request form

This communication applies to the Medicaid and Medicare Advantage programs for Healthy Blue.

Please submit this completed authorization form with all supporting documentation to ensure proper processing of your request to adjust claims as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

Provider name:	
Provider NPI:	
Provider TIN:	
Provider contact information:	

Cost Containment project number (if applicable):	
Document identification number (if applicable):	
Total recoupment dollar amount:	

Please list claim information below if the Cost Containment letter or other supporting claim/member detail is not provided with this request.

Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			

BMOPEC-0863-22 February 2022

Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			

If your request for recoupment exceeds the space provided, please attach an Excel file that includes all the data noted above. If you have questions related to the completion of this form, please call Medicaid Provider Services at **833-405-9086**.

I authorize Healthy Blue to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

_____ _____

Print name Signature

Return this form via:

Mail:
Healthy Blue
Attn: Cost Containment — Disputes
P.O. Box 62427
Virginia Beach, VA 23466-2437
Fax: **1-866-920-1874**

Note: Do not use this form if you are submitting a refund check. If you would like to submit a refund, please use the *Refund Notification Form* on our website at **https://provider.healthybluemo.com**.