PROVIDER REFUND FORM

Providers should send this completed form to the appropriate address for the member's TPA. For Family Care members, this can be found on your authorization. For all other programs, please use the TriZetto address. If you are unsure which address to use, you may call Customer Service at 800-963-0035.

TriZetto Claim Refunds:
Attn: Claim Refunds
1617 Sherman Ave
Madison, WI 53704

WPS Claim Refunds:
Attn: Claim Refunds
10201 W Innovation Dr
Wauwatosa, WI 53226

INSTRUCTIONS: Type or print clearly.

SECTION I – PROVIDER INFORMATION

Name – Provider Filing Refund	Telephone Number – Provider Filing Refund
Address – Provider Filing Refund (Street, City, State, ZIP code)	Name and Telephone Number – Contact Person

SECTION II – MEMBER INFORMATION

Member Name	Member Identification Number	Date(s) of Service

SECTION III – CLAIM INFORMATION OR ATTACH REMITTANCE ADVICE

Claim Number(s)			Check Issue Date	Check Number
Date(s) of Service From	To	Procedure Code or National Drug Code or Revenue Code	Billed Amount	Refund Amount
			Refund Total :	$ 0

SECTION IV – REFUND INFORMATION

Reason for Refund (Check One)

- ☐ Medicare paid
- ☐ Overpayment
- ☐ Other commercial health or dental insurance payment (please include EOB)
- ☐ Not our patient
- ☐ Wrong date of service
- ☐ Duplicate payment by My Choice Wisconsin
- ☐ Billing error
- ☐ Charges voided
- ☐ Item returned
- ☐ Other/Comments:

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SECTION IV - SIGNATURE

This information is accurate to the best of my knowledge.

SIGNATURE – Provider	Date Signed