home state health

PROVIDER REFUND FORM

Use this form when submitting a refund check to Home State Health.

Provider Name & Provider Tax ID#	**Member Name**
Claim(s)#	**Member Medicaid ID#**
Date(s)of Service	**Refund Amount & Check#**

Reason for Refund (please check):

- ☐ Claim was paid to wrong provider
- ☐ Claim was paid on wrong member
- ☐ Claim was paid on a member that was not eligible at the time of service
- ☐ Claim paid incorrect rate
- ☐ Claim was paid for a non-covered service
- ☐ Claim was paid as primary by HSH but member has other insurance as the primary. **Please submit the EOB/EOP of the primary insurance payment.**
- ☐ Claim was paid twice, this is a duplicate payment
- ☐ Other (please explain below)

_____

_____

_____

Date of Request: _____ Requestor Name: _____

Requestor Phone Number: _____

Mail completed form(s) and all related documentation such as EOP(s) to:

HOME STATE HEALTH
P.O. BOX 952790
ST. LOUIS, MO 63195-2790