# Provider Recoupment Request Form

**Important: Providers should confirm payment was made by SCAN and not a delegate.**
**THIS FORM IS ONLY FOR SCAN ISSUED PAYMENTS.**

**Instructions:** Please complete this form to initiate an immediate recoupment/offset of an identified overpayment of a SCAN claim **within 15 days** of overpayment identification/notice. The recoupment/offset will continue until the overpayment is recouped in full. All information below is required for offset initiation.

Submit this form to: claimsrecoveryunit@scanhealthplan.com or send email for additional options.

**Immediate Recoupment?** ☐ Note: Must be submitted no later than 16 days from the date of the notice.

## Claim(s) Information:

| Member ID# | Member First Name | Member Last Name | Date of Service | Claim # (found on notice or RA) | Claim Line # (if for partial claim) | Billed Amount | Over-payment Amount | Full or Partial Refund? |
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**If additional space is needed, please submit a spreadsheet with additional information*

## Provider Information:

Provider Name:

Provider Address:

City, State, Zip:

Phone #:
(xxx) xxx-xxxx

Today's Date:
(MM/DD/YYYY)

Tax ID #:

NPI #:

## Provider Contact Information:

Provider Contact Name:*

Organization (if other than Provider Office):

Email Address:

Phone #:

Preferred Method of Contact:

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