Texas Medicaid Refund Information Form

Please attach this completed form to your refund check made payable to TMHP, include a copy of the Medicaid Remittance and Status (R&S) report, and mail to the following address:

Texas Medicaid & Healthcare Partnership
Financial Department
12357-B Riata Trace Parkway
Suite 150
Austin, TX 78727

Date: _____ Refunding provider's name: _____
Provider's TPI: _____ Provider contact name: _____
Provider's telephone number with extension: _____
Provider's e-mail address: _____
Provider's NPI: _____ Taxonomy: _____

Claim Information:

Medicaid claim number (from *R&S*) refund should be applied to: _____
Patient's name: _____
Patient's Medicaid number: _____
Date(s) of service: _____

Reason for the Refund:

_____ Other insurance paid $_____ on this claim. **Attach EOB.** If no EOB available, complete the following:

Insurance company name: _____

Address: _____

Telephone number: _____ Policy number: _____

_____ TMHP audit identified overpayment
_____ Duplicate Medicaid payment
_____ Claim paid on the wrong patient's Medicaid ID number
_____ Claim paid on the wrong provider's Medicaid TPI/NPI/API
_____ Above-named person is not our patient
_____ Billing error
_____ Service was not rendered as billed
_____ Late credit for blood or pharmacy
_____ Medicare adjusted payment
_____ Patient's Medicare eligibility
_____ Other (describe in detail): _____
_____