

Credit Balance Refund Worksheet

Provider Name: _____

TPI: _____ NPI: _____

ICN/PCN	Patient Name	Company Name/Address	Policy Number	Group Number	Insurance Paid Amount	Refund Amount

Mail refund checks, made payable to TMHP, along with the "Credit Balance Refund Worksheet" to the following address:

Texas Medicaid & Healthcare Partnership
 CBA Worksheets & Refunds
 PO Box 202948
 Austin TX 78720-9981