West Provider Refund Form – Single Claim

Instructions

Please complete this form and mail with the personal refund check and supporting documentation. If you are using your own form or spreadsheet, please ensure it contains the information below. An electronic copy of this form is available in the Forms section at www.TRICARE-West.com. For refunds involving multiple claims, please use Provider Refund Form – Multiple Claims, which can also be found in the Forms section at www.TRICARE-West.com.

Payments received from WPS (TDEFIC, TRICARE Overseas) should be sent to Wisconsin Physicians Services.

Provider Information:

Provider Name: _____

Provider Tax Identification/National Provider Identification Number: _____

Refund Information:

Refund Amount: _____

Select the code that best describes the purpose of the refund.

- ☐ 200- Other Health Insurance (Beneficiary has other health insurance)
- ☐ 201- Third Party Liability (Automobile Accident, Home Accident, Workman's Compensation, etc.)
- ☐ 202- Paid Wrong Provider (Payment sent to wrong address or incorrect TIN)
- ☐ 204- Duplicate Payment (TRICARE Paid Twice)
- ☐ 208- Provider Billing Error (Claim submitted in error, with incorrect information and/or returned supplies)
- ☐ 281- System Pricing Error (TRICARE paid at a rate greater than contracted)
- ☐ Other- (Complete Comments Section)

Patient Information: *(Complete all available patient information related to the refund.)*

Patient's Name: _____

Sponsor Number: _____

Claim Number: _____

Procedure/Revenue Code(s): _____

Date(s) of Service: _____

Comments: *(List any additional information not provided above.)*

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