Indiana Farm Bureau®
Health Plans
Insured by Members Health Insurance Company

# OVERPAYMENT NOTIFICATION FORM – GENERAL INSTRUCTIONS FOR PROVIDERS

Providers use this form when they identify an overpayment and need to return a refund and/or when providers are requesting action by Indiana Farm Bureau Health Plans. Following the guidelines below will expedite the handling of your overpayment.

1. Mark the appropriate box on the Overpayment Notification form to indicate how you would like Indiana Farm Bureau Health Plans to handle your overpayment. Your options include:

    a. **Check attached:** Please submit a check along with the completed Overpayment Notification Form and mail them to

    **Indiana Farm Bureau Health Plans**
    **Attn: Provider Recoveries**
    **PO Box 1424**
    **Columbia, TN 38402-1424**

    b. **Request deduction/offset from your next remittance advice:** By checking this box, you agree to allow Indiana Farm Bureau Health Plans to deduct the overpayment amount from your next claim payment. Details regarding the deduction will be within your Remittance Advice for the adjusted claim.

    c. **Please send a refund request letter.** Per your request, Indiana Farm Bureau Health Plans will send you an Overpayment Refund Request letter documenting the details of the claim and overpayment amount for refund. Once you receive the initial letter, you can send in your payment. Please attach your payment to the refund request letter to expedite processing.

2. Attach any required documentation in order to expedite the adjustment and for audit purposes as indicated below:

    a. A copy of the Medicare Explanation of Benefits (MEOB) or Medicare electronic transmittal is required if the reason for the overpayment is due to a Medicare adjustment/correction/reversal.

    b. A copy of ALL insurance EOBs involved when Medicare is paying **secondary** to another insurance plan.

    c. A copy of the other insurance EOB involved when Medicare is paying **primary** to Indiana Farm Bureau Health Plans and another insurance plan, creating an overpayment.

If you have any questions or need assistance with the completion of this form, please call Customer Service at 1-888-964-0314 Monday through Friday, 8 a.m. to 4:30 p.m. CST.

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# Overpayment Notification Form

**Use this form when notifying Indiana Farm Bureau Health Plans of an overpayment.**
If you have any questions or need assistance with the completion of this form, please call Customer Service at 1-888-964-0314 Monday through Friday, 8 a.m. to 4:30 p.m. CST.

**Today's Date:**_____

☐ **Check attached**

☐ **Request deduction/offset from your next remittance advice.** By checking this box you agree to allow Indiana Farm Bureau Health Plans to deduct the overpayment amount from your next claim payment. Details regarding the deduction will be within your Remittance Advice for the adjusted claim. Signature of Authorized Personnel or Provider is **required.**

Authorized Signature:_____ Title: _____

Print Name: _____ Date: _____

☐ **Please send a refund request letter.**

| **Claim/Patient Information** | | | |
|---|---|---|---|
| **Rendering Provider** | | **Rendering Provider NPI** | |
| **Patient Name** | | **Claim #/Reference #** | |
| **Patient Account #** | | **Date of Service** | |
| **INFBHP Subscriber ID** | | **Claim Total Charge** | $ |
| **Date of Birth** | | **Overpayment Amount** | $ |

| **Who should we call if we have a question?** | |
|---|---|
| **Contact Person** | |
| **Title** | |
| **Contact Number** | **Ext.** |
| **Provider's Mailing Address** | |
| **Attention** | |
| **Provider Group Name** | |
| **Address** | |
| **City, State ZIP** | |

Please mail this form and any supporting documentation to:

**Indiana Farm Bureau Health Plans**
**Attn: Provider Recoveries**
**PO Box 1424**
**Columbia, TN 38402-1424**

| **Reason for Overpayment** | |
|---|---|
| ☐ | Medicare Adjustment or Reversal **Required**: Supporting MEOB or MRA |
| ☐ | Claim billed in error |
| ☐ | Multiple Payers (Coordination of Benefits) for when Medicare is **secondary** to another insurance plan<br>**Required**: Supporting EOB, MEOB and/or MRA |
| ☐ | Multiple Payers (Coordination of Benefits) for when Medicare is **primary** to INFBHP and another insurance plan<br>**Required**: Supporting EOB, MEOB and/or MRA for other secondary insurance plan **only** |
| ☐ | Member is not your patient |
| ☐ | Duplicate payment. Other claim number is: |
| ☐ | Services not rendered: |
| ☐ | Other: |