Third Party Recovery Overpayment Form

Date_____

Name of Medical Facility _____

NC State Health Plan Member_____

NC State Health Plan ID # _____

Type of Injury _____

Dates(s) of Service _____

Amount of overpayment/refund sent to State Health Plan_____

Attorney's name, phone number & address (if applicable) _____
_____
_____

Insurance company name, phone number & address (if applicable) _____
_____
_____

Reason for overpayment/refund _____

This form should ONLY be completed when overpayments are due back to the State Health Plan because a third party liability carrier has already paid. Please complete the information on this Third Party Recovery Overpayment Form to the extent known, attach to the refund/overpayment check and forward to NC State Health Plan Overpayments, PO Box 20733 Raleigh, NC 27619.

If you should have any questions, please feel free to contact Health Management Systems at (800) 294-2757, extension 4.