Inland Empire Health Plan

RECOVERY REQUEST

Letter Sent Date:	
Provider of Service Information	
Provider Name:	
Vendor Street Address:	
Vendor City, State & Zip:	
Patient Information	
Member Name:	
Member ID/Patient Account Number:	
Date of Service:	
IEHP Claim Number/FL Number:	
Overpayment Calculation	
Correct Payment Amount	$
Payment Made to Provider	$
Requested Refund Amount	$
Reason for Refund	
☐ Incorrect Case Rate	☐ IPA responsibility
☐ Duplicate	☐ Other insurance paid as primary
☐ Services Billed in Error	☐ CCS paid
☐ Overpaid according to contract	☐ Medi-Cal Fee For Service
☐ Other	
Additional Comments	
Enclose a check payable to IEHP or authorize IEHP to deduct this overpayment from future claims payments by signing this form. Return this form to the address or fax number listed below.	

Authorized by: _____ Title: _____ Date: _____

P.O Box 1800, Rancho Cucamonga, CA 91729-1800 | Attn: Audit Recovery Department

Fax # (909) 296-3636