Gateway Health Plan®
Refund Form

Instructions for Providers: Gateway Health Plan® cannot accept verbal requests to retract claim(s) overpayments. Providers may complete and submit a Refund Form or a letter that contains all of the information requested on this form along with your check to: **Gateway Health Plan®, Attention: Finance Department, US Steel Tower, Floor 42, 600 Grant Street, Pittsburgh, PA 15219**

PLEASE COMPLETE

Date________________ Group Name____ Group Number__________________

Address____ Phone Number __________________

Practitioner Name______________________________________ Individual Provider Number______________________________

Vendor Name____ Tax Identification Number ______________________________

Contact Person at Provider's Office____ Phone Number___________________

E-mail Address____

Member/Claim Information

Name	Gateway ID #	DOS	Claim Number	Remit Amount

(Please use a separate sheet for additional Member/Claim Information)

Reason for Refund:

Payment of Outstanding Credit Balance AR
Duplicate Payment
Medicare
Other Insurance_________________________
Provider Billing Error
Unable to Identify Patient
Multiple Payments (If multiple members are affected, check box and attach a copy of your Remit with names highlighted

COMMENT:____

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6/17/2009