

Request for Reimbursement Letter

To (Complete Provider's Information)

Name:

Address:

Address:

City/State/Zip:

From (Complete Your Information)

Name:

Address:

Address:

City/State/Zip:

Phone Number:

Regarding

Patient Name:

Date of Birth:

Patient Account Number:

Benicorp Identification Number:

Date:

To Whom It May Concern:

It has come to my attention that an overpayment exists on a claim from your facility for _____
(*patient's name*). The claim was incurred on _____ (*date of the claim*) in the amount of
\$ _____ (*dollar amount of the claim*).

I am attaching an Explanation of Benefit form from Benicorp Insurance Company indicating that payment in
the amount of \$ _____ (*amount paid by Benicorp*). I am also attaching proof that I also made a
payment on the same claim in the amount of \$ _____ (*amount member paid*).

I respectfully request that a reimbursement for the overpayment in the amount of \$ _____
(*amount of the overpayment*) be paid directly to me at the address listed above. I would appreciate the
processing of a reimbursement check at your earliest convenience. If you have any questions, please feel free
to contact me at the phone number listed above.

Sincerely,

(*Signature*)