Refund Form

Important:

- Include the check(s) to be refunded and a copy of the remittance notice.
- Please make checks payable to Community Care, Inc.
- A separate form is required for each patient/member.

Mail To:
Community Care, Inc.
Attn: Finance Department
205 Bishops Way
Brookfield, WI 53005

Contact Name:

Contact Phone Number:

Contact E-mail:

Billing Provider Name:

Address (City, St and Zip):

Tax Identification Number (TIN):

Billing NPI Number:

Member/Patient Name:

Member/Patient Date of Birth:

DCN(s) – Document Control Number(s):

Date(s) of Service:

Refund Check Date:

Refund Check Number:

Amount of Refund Check:

Reason for Refund: *check box for refund reason*:

☐ Other Insurance/Medicare is primary *(attach copy of primary payer EOB)*
☐ Corrected claim *(include copy of corrected claim)*
☐ Duplicate payment
☐ Provider billed in error
☐ Other: