Molina Healthcare
RETURN OF OVERPAYMENT FORM

Date: _____

Provider name: _____

Provider tax identification number: _____

Provider contact person: _____

Provider phone number: _____

Please fill out the form below with all applicable information.

Molina claim number	Molina check number	Amount refunded to Molina	Provider check number (if applicable)

Reason the payment is being returned to Molina Healthcare (check one):

☐ Claims are for patients not affiliated with this office

☐ Member has primary insurance and claim was paid as primary

☐ Claim was overpaid due to a billing error (please send corrected claim if needed)

☐ Other (please explain) _____

_____

_____

_____

Please **see next page for remittance address.**

Send claim overpayment checks via regular mail to:

Molina Healthcare Medicaid
Attn: Recoveries Lockbox
401 Market Street
Box 780192
Philadelphia, PA 19178-0192

Send claim overpayment checks via overnight mail to:

Lockbox # 780192
Molina Healthcare Medicaid
Attn: Recoveries Lockbox
MAC Y1372-045
401 Market Street
Philadelphia, PA 19106