Physician and Facility Claims Refund Form

Providers, facilities, and other ancillary care professionals should complete this form to submit a refund.

Please attach this completed form to your refund check made payable to True Health New Mexico. Enclose a copy of the True Health New Mexico Explanation of Payment and mail to the following address:

True Health New Mexico
Attention: Finance
P.O. Box 36719
Albuquerque, NM 87176

PROVIDER/GROUP/FACILITY INFORMATION		
Refunding Physician/Group/Facility Name:		**Date:**
Provider TIN:	**Provider NPI:**	**Taxonomy:**
Contact Name:	**Phone Number:**	
Fax Number:	**Email Address:**	
Billing Address:		
City:	**State:**	**Zip Code:**

MEMBER INFORMATION	
Last Name:	**First Name:**
Date of Birth:	**ID Number:**

CLAIM INFORMATION		
☐ **Provider**	☐ **Facility**	☐ **Ancillary Health Care Professional (DME, lab, etc.)**
Claim Number:		**Date of Service:**
Billed Amount:		**Paid Amount:**

Reason:
☐ Provider not affiliated w/group/facility ☐ Above-named person is not our patient ☐ Duplicate payment
☐ Billing error ☐ Service was not rendered as billed ☐ Primary insurance adjusted payment
☐ Patient is Medicaid-eligible ☐ Patient is Medicare-eligible ☐ Other; please enter reason in box below

Other:

***If another insurance paid as primary on claim, please attached primary Explanation of Payment (EOP). If no EOP is available, please complete the following below:**

Insurance Company Name:	Telephone Number:
Member Policy Number:	