

HealthChoice

MEMBER AUDIT FORM

If you think an error has been made on your bill, and you wish to participate in the member audit program, complete this form and mail it to HP Administrative Services, LLC (HP) at PO Box 24110, Oklahoma City, OK 73124. If you have any questions regarding the member audit program, contact HP at 1-405-416-1800 or 1-800-782-5218.

NOTE: HOSPITAL BILLS PROCESSED BY THE FLAT RATE DRG DO NOT QUALIFY FOR THE MEMBER AUDIT AWARD.

Member Name: _____

Address: _____

SSN or Member ID: _____

Patient Name: _____

Please list below the items which were overpaid on your accounts and attach documentation:

Date	Item	Amount
_____	_____	_____
_____	_____	_____

Reason(s) you believe these items were billed in error:

Name of party, at the provider's office, to whom you reported these errors:

Name: _____ Title: _____

Provider Name: _____

Address and _____

Phone: _____

Attach a copy of the corrected billing and any correspondence regarding this claim.

Signature of Employee: _____ Date: _____

***** FOR OSEEGIB USE ONLY *****

The above mentioned billing error should be adjusted and the overpayment requested from the provider. The signature below indicates that this claim qualifies for the Member Audit Award which should be issued to the member upon receipt of the overpayment.

Authorized Signature: _____