

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 P.O. 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: Inpatient hospital and ambulatory surgical centers charges are not eligible for this program because billing is based on individual charges.

Member Name: _____

Address: _____

SSN or Member ID: _____

Patient Name: _____

List the items that were overpaid on your account and attach documents to this form.

Date	Item	Amount
_____	_____	_____
_____	_____	_____

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

Provide the name and contact information of the person at the provider's office you reported these errors to:

Name: _____ Title: _____

Provider Name: _____

Address and Phone Number: _____

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

Signature of Employee: _____ Date: _____