

RETURN TO:  
 ROCKY MOUNTAIN HEALTH PLANS  
 CLAIMS ADJUSTMENT TEAM  
 P.O. BOX 10600  
 GRAND JUNCTION, CO 81502-5600

**ATTACH THIS FORM TO YOUR REFUND CHECK**

Date: \_\_\_\_\_

Provider check #: \_\_\_\_\_

Provider check \$ amount: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Tax ID or NPI: \_\_\_\_\_

**Required information to process a refund check:**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Patient Account #: \_\_\_\_\_ Claim#: \_\_\_\_\_

**Reason for Refund – (√) Check One:**

- Rocky Mountain Health Plans Duplicate Payment
- Other Insurance Paid (Circle One):  
 Work Comp    Auto    Third Party    Medicare    Other Insurance

Please note: If another insurance carrier has paid (including Medicare), a copy of the explanation of benefits must be attached or your check may be returned to you.

**Explanation of Refund (required):**

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Thank you for your cooperation.

**Claims Action Request and Check Refund  
Instructions**

- 1) Determine the reason the claim was not processed as you expected:
  - a. Review the messages on the Remittance Advice (RA), Explanation of Payment (EOP) or Provider portal.
  - b. If the message is unclear, follow up with Customer Service for clarification. (Note: The payers have indicated that sometimes they can make the correction based on a phone call alone.)
  - c. Determine if the reason for the original claims processing allows the claim to be corrected. (Note: Plan policies and contractual limitations cannot be corrected.)
- 2) The preferred request is via the Claims Action Request or through a phone call to customer service. In these cases we would adjust the claim and recover any overpayment through the voucher. If the request is done with a check refund the refund must be a full refund of the original payment. If the check is not a full refund then any overpayment will be recovered through the voucher and your check will either be returned or if there is an outstanding balance on your account it will be applied to the balance.
- 3) Both the Claims Action Request and Check Refund forms must be filled out completely with a copy of the Remittance Advice or Explanation of Payment attached, reflecting the original processing. If you are correcting the claim, include it with the form as well.

- 4) Mail the completed form and attachments for Colorado members to:

RMHP  
PO Box 10600  
Grand Junction, CO 81502-5600  
Or Fax to Number Designated above

- 5) Mail the completed form and attachments for Wyoming members to:

WINhealth Partners Medicare Plan  
c/o RMHP  
PO Box 60160  
Grand Junction, CO 81506-3900  
Attention: Judi Everett