# Explanation of Check Refund

Complete this form entirely. Print, sign, and mail this form and any supporting documents to the address below. Incomplete forms will delay processing and may result in the returning of funds. View the Explanation of Check Refund Quick Track Training video for help and faster processing using the portal.

Mail to: AR Medicaid Refunds 9292
PO Box 7411556
Chicago, IL 60674-1556

| **PROVIDER** | |
|---|---|
| Name: | Paid to Provider Number: |

| **REFUND** | | |
|---|---|---|
| Check Number: | Check Date: | Check Amount: |

Complete a column for ***EACH CLAIM*** being refunded. Include additional forms if needed.

| | **Claim 1** | **Claim 2** | **Claim 3** |
|---|---|---|---|
| 13-digit Claim Number (from RA) | | | |
| Client's ID Number (from RA) | | | |
| Client's Name (Last, First) | | | |
| Date(s) of Service on Claim | | | |
| Date of Medicaid Payment | | | |
| Date(s) of Service Being Refunded | | | |
| Services Being Refunded [Procedure and Type of Service Code(s)] | | | |
| Amount of Refund | | | |
| **IF an Insurance Payment was Received** | | | |
| Amount of Insurance Received | | | |
| Insurance Co. Name | | | |
| Insurance Co. Address | | | |
| Insurance Co. Policy Number | | | |
| **Reason for Refund Code** | | | |

**Refund Codes**

| | |
|---|---|
| **BILL** | A billing or keying error was made. |
| **DUP** | A payment was made by Arkansas Medicaid more than once for the same service(s). |
| **INS** | A payment was received from a third-party source other than Medicare. |
| **MC ADJ** | An over application of deductible or coinsurance by Medicare has occurred. |
| **PNO** | A payment was made on a recipient who is not a client in this office. |
| **OTHER** | |

If you selected "Other" for the reason for refund, provide a detailed explanation below.

| | |
|---|---|
| Name (type or print): | |
| Signature: | |
| Telephone: | Date: |