West Provider Refund Form – Multiple Claims

Instructions

Please complete this form and mail with the personal refund check and supporting documentation. If you are using your own form or spreadsheet, please ensure it contains the information below. An electronic copy of this form is available in the Forms section at www.TRICARE-West.com. For refunds involving a single claim, please use Provider Refund Form – Single Claim, which can also be found at www.TRICARE-West.com in the Forms section.

Payments received from WPS (TDEFIC, TRICARE Overseas) should be sent to Wisconsin Physicians Services.

Provider Information:

Provider Name:
Provider Tax Identification/National Provider Identification Number:

Refund Information: *(Enter the corresponding number in the applicable Refund Reason fields below.)*

200- Other Health Insurance (Beneficiary has other health insurance)	208- Provider Billing Error (Claim submitted in error or with incorrect information and/or returned supplies)
201- Third Party Liability (Automobile Accident, Workman's Compensation, etc.)	
202- Paid Wrong Provider (Payment sent to wrong address or TIN)	281- System Pricing Error (TRICARE paid more than contracted)
204- Duplicate Payment (TRICARE Paid Twice)	Other- (Complete Comments Field)

Patient Information:

Patient Name:		Comments:
Sponsor #:		
Claim #:		
Procedure/Revenue Code(s):		
Date(s) of Service:		
Refund Reason:		
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PGBA, LLC.
TRICARE West Region Finance
PO Box 202111
Florence, SC 29502-2111

PGBA®
A CELERIAN GROUP COMPANY

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