APPENDIX E

CREDIT BALANCE REPORT FORM

PROVIDER NAME:		**CONTACT PERSON:**	
PROVIDER NUMBER:		**TELEPHONE NUMBER (including area code):**	

QUARTER ENDING (circle or check one): 06/30 09/30 12/31 03/31 **YEAR:** PAGE_____ OF_____

#	MEMBER NAME	MEDICAID ID NO	TCN	DATE(S) OF SERVICE	MEDICAID PAYMENT	COB PAYMENT	AMOUNT DUE TO MEDICAID	INSURANCE PLAN NAME; REFUND REASON *	POLICY NUMBER POLICYHOLDER NAME **
1									
2									
3									
4									
5									
6									
7									
8									
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10									
11									
12									
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16									
17									
18									
19									
20									
TOTALS									

*** IF CREDIT BALANCE NOT RELATED TO OTHER COVERAGE (COB), PROVIDE REFUND REASON. ** IF AVAILABLE, PLEASE ATTACH A COPY OF THE OTHER INSURANCE ID CARD TO THIS FORM.**

NOREFUNDSIDENTIFIED **COMPLETED BY:**

TITLE: **DATE:**