Simply Healthcare Plans, Inc.
Clear Health Alliance
Medicaid Managed Care

Recoupment Notification Form

Please submit this completed authorization form with all supporting documentation to ensure proper processing of your request to adjust claims as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

Provider name:	
Provider NPI:	
Provider TIN:	
Provider contact information:	

Cost Containment project number (if applicable):	
Document identification number (if applicable):	
Total recoupment dollar amount:	

Please list claim information below if the Cost Containment letter or other supporting claim/member detail is not provided with this request.

Claim number:	Member number:	Service dates:		Recoupment amount:
	Recoupment reason:			
Claim number:	Member number:	Service dates:		Recoupment amount:
	Recoupment reason:			
Claim number:	Member number:	Service dates:		Recoupment amount:
	Recoupment reason:			
Claim number:	Member number:	Service dates:		Recoupment amount:
	Recoupment reason:			

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

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Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			

If your request for recoupment exceeds the space provided, please attach an Excel file that includes all the data noted above. For questions related to the completion of this form, please call Medicaid Provider Services at **1-844-405-4296** or Medicare Provider Services at **1-844-405-4297**.

I authorize Simply Healthcare Plans, Inc. and Clear Health Alliance to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

_____ _____

Print name Signature

Return this form via:

Mail:
Simply Healthcare Plans, Inc.
Attn: Cost Containment — Disputes
P.O. Box 62427
Virginia Beach, VA 23466-2437

Fax: **1-866-920-1874**

Note: Do not use this form if you are submitting a refund check. If you would like to submit a refund, please use the refund notification form at:

- **https://provider.simplyhealthcareplans.com/florida-provider** for Simply Healthcare Plans, Inc. providers.
- **https://provider.clearhealthalliance.com/florida-provider** for Clear Health Alliance providers.

Mail a check along with the supporting documentation to:

Simply Healthcare Plans, Inc.
Attn: Cost Containment — Payments
P.O. Box 933657
Atlanta, GA 31193-3657