Refund Request

CONCIERGE
Third Party Administrator

Date:

Street Address:

City: State: Zip Code:

Insured:
Patient:
Acct #:
Group #:
Employee #:
Claim #:
DOS:

To Whom It May Concern:

On , we sent you check number in the amount of $.

This has caused an overpayment of $ due to .

Please send a refund check in the amount of $ payable to **Concierge** and mail to the address listed below. Please include a copy of this letter with the refund check.

Please contact our office if there are any questions regarding this letter. Thank you in advance for your cooperation in this matter. Once the refund has been received, the claim will be re-processed if applicable.

Sincerely,
Concierge