CSHCN Services Program Refund Information Form

Please attach this completed form to your refund check made payable to TMHP, include a copy of the CSHCN Services Program Remittance and Status (R&S) report, and submit to:

Texas Medicaid & Healthcare Partnership (TMHP)
Financial Department
12365-A Riata Trace Pkwy., Ste. 100
Austin, TX 78727

Notes:

1. If requesting a refund for multiple claims, you can issue only one check. The check must be issued for the total amount to be refunded.
2. If this request is for multiple claims, attach a separate spreadsheet with the claim information and reason for refund, or submit a separate CSHCN Services Program Refund Information Form for each claim.
3. Attach an R&S report that contains the claim associated with the refund for each claim.

Provider Information		
Refunding provider's name:		
Contact name:	Telephone number:	
Street/City/ZIP:		
E-mail address:	NPI:	Taxonomy:

Claim Information (attach an R&S that contains the claim associated with the refund)		
Client name:	Date of service:	Refund amount:
Claim number:	CSHCN Services Program number: 9-	-00

Reason for the refund

- ☐ TMHP audit identified overpayment
- ☐ Duplicate CSHCN Services Program payment
- ☐ Medicare adjusted payment
- ☐ Claim paid on the wrong client's CSHCN Services Program identification number
- ☐ Claim paid on the wrong provider's CSHCN Services Program NPI/API
- ☐ Above-named person is not our client
- ☐ Billing error
- ☐ Service was not rendered as billed
- ☐ Late credit for blood or pharmacy
- ☐ Client's Medicare eligibility
- ☐ Other insurance paid $_____ on this claim. **Attach explanation of benefits (EOB).** If no EOB available, complete the fields below.

Insurance company name:
Address:
Telephone number:
Policy number:
Subscriber ID:
Other (describe in detail):