REFUND OF MONIES

PLEASE REMIT TO: Cash Processing • Avalon® Insurance Company • P.O. Box 773301 • Harrisburg, PA 17177-3301

Please be sure to include this form along with your remittance amount. If possible, please attach a copy of the corresponding **Statement of Remittance**. Providing patient information enables us to credit your account in a more efficient and timely manner.

If you have questions, please contact our Customer Service Department at 800.562.6298 between 8 a.m. and 8 p.m., Monday through Friday.

Provider Group Name | Provider Group ID Number | Date

Provider Mailing Address | City | State | ZIP Code

* Remittance Amount | Avalon Insurance Company Check Number | Prefix | Avalon Insurance Company Member ID Number | Claim Number/ SOR Control Number

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Patient Name | Patient Account Number | Date of Service

Practitioner ID Number | Practitioner Name

**A refund for the total amount of the claim specified above is required. Adjustment of the entire transaction is necessary to ensure accurate posting of the member's financial responsibility. Please do not remit an adjusted amount.*

Payment Error Occurred for the Following Reason(s):

- ❑ Unable to identify patient
- ❑ Provider Billing
  - *Explanation:*
- ❑ Duplicate Payment
  - *Explanation:*
- ❑ Processing Error
  - *Explanation:*
- ❑ Other
  - *Explanation:*
- ❑ Other Insurance Liability:
  - ❑ Workers' Compensation
  - ❑ Motor Vehicle Related
  - ❑ Security℠/Senior℠ — *HIC Number*
  - ❑ Other Insurer