



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	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Provider Mailing Address	City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

* Remittance Amount	Avalon Insurance Company Check Number	Alpha Prefix	Avalon Insurance Company Member ID Number	Claim Number/SOR Control Number
\$ <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient Name	Patient Account Number		Date of Service	
<input type="text"/>	<input type="text"/>		<input type="text"/>	
Practitioner ID Number	Practitioner Name			
<input type="text"/>	<input type="text"/>			

**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

SecuritySM/SeniorSM

HIC Number

Other Insurer