Credit Balance Refund Data Sheet

WellSense HEALTH PLAN

Provider information (please print information clearly)				
Provider Payee name as shown on EOB		Provider Payee # as shown on EOB		
Contact Name	Title	Phone Number	Ext.	Fax Number
Email (we don't send PHI via unencrypted email)				

Providers should not submit refund checks for credit balance payments; instead, please contact us using the methods below and we will adjust your claim(s) and recover the credit balances through future payment offsets. This is a preferred method and ensures quicker turnaround time.

If you must send us a refund check because you can't submit a retraction request, please fill out check info below:

Check Issuer_____ Check No._____ Check Date _____Check Amount _____

Please submit the form by:

Upload to Health Trio online portal (wellsense.healthtrioconnect.com) : please be sure to include the **Claim Review Form** in addition to the Credit Balance Refund Data Sheet and supporting documents.

Mail:
WellSense Health Plan
Attn: Credit Balance
529 Main Street, Suite 500
Charlestown, MA 02129

Fax: 617-897-0811

For Health Trio issues, please contact your Provider Relations Consultant. For all other issues, please contact 617-748-6229

Patient information (please print clearly)				
Patient Name	Member ID	Patient Acct#	Date of service (DOS)	
Claim No.	Original payment# or check no.	Amount billed	Amount paid	Refund amt.

Last Updated 01/20/2023

Credit Balance Refund Data Sheet

Please check one of the following reasons for refund:

	Billed in error
	Charges removed
	Cashed in error
	Duplicate payments
	TPL (Copy of Auto Insurance/WC payment required)
	COB (Copy of Primary Insurance EOB required)
	Other (please explain, e.g. list procedure code, service line) _____

Completed by _____ Date _____ Last Updated 04/04/2023