



Completion of this form in its entirety is required in order to assist with accurate and timely reprocessing of your claims. Include any required documentation with your submission.

**Overpayment Recovery Form**

Please mail this form and any other required documentation to Commonwealth Care Alliance, Inc. (CCA) at the address below.

Do not use this form for the following:

- Submission of Appeals or Correspondence
- Sending payment

Commonwealth Care Alliance, Inc.  
 Attention: Claim Recovery Department  
 230 N. Main St.  
 Dayton, OH 45402

Claim Number	Member ID	Date of Service	Amount of Overpayment	Claim Paid Amount	Reason for Refund
123456789XX00	1234567890	00/00/0000	\$50000.00	\$50000.00	Coordination of Benefits

Provider Information	
Provider Name	
Provider Tax ID	
Provider NPI	
Remittance Address	
Service Address	
Alternate Remit Address (if different than Provider Remit)	
Contact Name	
Contact Phone	