

# OVERPAYMENT/VOUCHER DEDUCTION REQUEST



**Asuris**  
Northwest Health  
A Regence Affiliate

Submitted By	Provider Number	Date
--------------	-----------------	------

**We request that a deduction be made on our payment voucher for the following:**

Patient Name	Patient Account Number	Patient Birth Date
Service Dates		
Subscriber ID Number	Subscriber Name	

Claim Number: \_\_\_\_\_

**Reason for Deduction(s):**

Other Insurance Payment

Amount Paid	Patient Responsibility after Primary Carrier Payment
\$ _____	\$ _____
By _____	
Policy Holder _____	Policy Number _____

- Duplicate Payments     
  Late Credits     
  Cancelled Charges     
  Third Party Payment
- Other (Please Specify)

\_\_\_\_\_

\_\_\_\_\_

Comments

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If Asuris Northwest Health has questions regarding this request, the person to contact at this provider's office is:**

Name	Telephone Number	Time to Contact
_____	_____	_____

**SUBMIT THIS REQUEST TO:**

**Asuris Northwest Health**  
 ATTN: Mail Stop S620  
 PO Box 21267  
 Seattle, Washington 98111-3267