

OVERPAYMENT/VOUCHER DEDUCTION REQUEST



Submitted By	Provider Number	Date
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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):

Response to recoupment request

Other Insurance Payment Amount Paid \$ _____ Patient Responsibility after Primary Carrier Payment \$ _____

By _____

Policy Holder _____ Policy Number _____

Duplicate Payment Late Credit Cancelled Charge 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 _____ Phone Number _____ Best Time to Contact _____

MAIL OR FAX REQUEST TO:

Asuris Northwest Health Recovery
ATTN: Overpayment Recovery
P.O. Box 21267 – M/S S620
Seattle, WA 98111-3267

FAX: 1 (888) 335-2995