Explanation of Check Refund

Complete this form entirely. Print, sign, and mail this form and any supporting documents to the address below. Incomplete forms will delay processing and may result in the returning of funds. View the Explanation of Check Refund Quick Track Training video for help and faster processing using the portal.

Mail to: Arkansas Department of Human Services
PO Box 505616
St. Louis, MO 63150-5616

PROVIDER	
Name:	Paid to Provider Number:

REFUND		
Check Number:	Check Date:	Check Amount:

Complete a column for ***EACH CLAIM*** being refunded. Include additional forms if needed.

	Claim 1	**Claim 2**	**Claim 3**
13-digit Claim Number (from RA)			
Client's ID Number (from RA)			
Client's Name (Last, First)			
Date(s) of Service on Claim			
Date of Medicaid Payment			
Date(s) of Service Being Refunded			
Services Being Refunded [Procedure and Type of Service Code(s)]			
Amount of Refund			
IF an Insurance Payment was Received			
Amount of Insurance Received			
Insurance Co. Name			
Insurance Co. Address			
Insurance Co. Policy Number			
Reason for Refund Code			

Refund Codes

BILL	A billing or keying error was made.
DUP	A payment was made by Arkansas Medicaid more than once for the same service(s).
INS	A payment was received from a third-party source other than Medicare.
MC ADJ	An over application of deductible or coinsurance by Medicare has occurred.
PNO	A payment was made on a recipient who is not a client in this office.
OTHER	

If you selected "Other" for the reason for refund, provide a detailed explanation below.	
Name (type or print):	
Signature:	
Telephone:	Date: