


Overpayment Notification

This letter is generated to alert a provider of an overpayment. For additional notification, a corresponding remittance notification is created.



HealthChoice
PO Box 30527
 Salt Lake City UT 84130-0541

PERFECT PROVIDER
 123 HAPPY LANE
 OKLAHOMA CITY OK, 73105

The date of this letter is important because it corresponds to the remit notification.

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DECEMBER 4, 2022

The following claim(s) have been adjusted, resulting in the identification of an overpayment. Each overpayment has been assigned a financial control number (FCN).

- If you are a network provider, you will have 90 days to submit a refund for the FCN(s) listed below.
- If the refund is not received within 90 days, recoupment will be attempted from future payments.
- If you are a non-network provider, recoupment attempts will begin immediately. The FCN will be reflected on the remittance advice and/or ANSI 835 files when a recoupment is applied.
- If you prefer to mail in your check with a copy of this letter, please do so within 90 days.

This will be the only written notification of the overpayment. Please retain this letter as a reference for posting of the recoupment once the transaction has occurred. This information will also be available on HealthChoiceOK.com under the **Refund tracking** search option. This search option will display all details of the FCN.

- If you already have an account, go to HealthChoiceOK.com and enter your username and password in the upper-right corner.
- If it's your first time visiting us, click **New user? Register here** to open an account.
- Complete the online registration information.
- Enter your **Tax ID number** and **provider name**. You may only view FCN information associated with that Tax ID.


1) FCN 000000000 2) Overpayment Amount \$
 3) Reason for Overpayment

4) Patient Acct Number	5) Patient Name	6) Date of Service	7) EDI ID Number
8) Member ID	9) Member Name		
10) Plan Name			
HEALTHCHOICE			

Bullets 1-10 are added to help correspond with the provider's remits. Refer to the following examples for Remit Advice Notification and Remit Advice Recoupment.


Remit Advice Notification

A recoupment notification can be included in a regular remit or as a standalone. The date of the remit is the same date as the letter.

PERFECT PROVIDER 123 HAPPY LANY OKLAHOMA CITY OK, 73105		Remittance Advice for Period Ending 12-04-22 UMR PO BOX 30511 SALT LAKE CITY UT 84130 1-866-381-3815 10) HEALTHCHOICE STATE OF OKLAHOMA OFFICE MANAGEMENT AND ENTERPRISE							Visit our web-site at HealthChoiceOK.com to obtain eligibility, benefit, and claim information on behalf of your patients 24 hours/day, 7 days/week.					
		Federal ID No.												
Dates From/To	Service Code	Charged Amount	Allowed Amount	Deductible	Copay	Coinsurance	Discount Managed Care Adjust	Ineligible	Withheld	OC	ANSI Code	Paid	Patient Responsibility	
9) EMPLOYEE:		5) PATIENT:		7) CLAIM NUMBER:		8) ID#								
4) ACCOUNT NUMBER:		100.00-		100.00-		.00		.00		.00		.00		
040423	91303	CORRECTION	.01-	.00	.00	.00	.00	.01	.00	01		.00	.00	
		FEE EXCESS								45				
040423	0041A	CORRECTION	100.00	.00	.00	.00	.00	100.00-	.00	01	A1	.00	100.00	
		3) ADD'L INFO NEEDED FROM PROV												
040423	91303	CORRECTION	.01	.00	.00	.00	.00	.01-	.00	01	A1	.00	.01	
		ADD'L INFO NEEDED FROM PROV												
PRVD LVL BAL RSN: WO		1) FCN 000000000000		CLP07								2) 100.00		
040423			.00	.00	.00	.00	.00	.00	.00	00		100.00	.00	
TOTAL		.00		100.00-		.00		.00				.00		
		HEALTHCHOICE STATE OF OKLAHOMA												

Remit Advice Recoupment

A recoupment notification can be included in a regular remit or as a standalone. The below example shows a recoupment in the amount of \$26.51. The minus sign behind \$26.51 indicates a recoupment; the amount is subtracted from the total paid.

PERFECT PROVIDER 123 HAPPY LANE OKLAHOMA CITY OK, 73105		Remittance Advice for Period Ending 12-04-22 UMR PO BOX 30511 SALT LAKE CITY UT 84130 1-866-381-3815 10) HEALTHCHOICE STATE OF OKLAHOMA OFFICE MANAGEMENT AND ENTERPRISE							Visit our web-site at HealthChoiceOK.com to obtain eligibility, benefit, and claim information on behalf of your patients 24 hours/day, 7 days/week.					
		Federal ID No.												
Dates From/To	Service Code	Charged Amount	Allowed Amount	Deductible	Copay	Coinsurance	Discount Managed Care Adjust	Ineligible	Withheld	OC	ANSI Code	Paid	Patient Responsibility	
9) EMPLOYEE:		5) PATIENT:		7) CLAIM NUMBER:		8) ID#								
4) ACCOUNT NUMBER:		PRVD LVL BAL RSN: WO		1) FCN 000000000000		CLP07						26.51-		
020322			.00	.00	.00	.00	.00	.00	.00	00		26.51-	.00	
TOTAL		.00		.00		.00		.00				2) 26.51-		
		HEALTHCHOICE STATE OF OKLAHOMA												
EMPLOYEE:		PATIENT:		ID#										
ACCOUNT NUMBER:		CLAIM NUMBER:												
110622	99213	150.00	107.64	.00	30.00-	.00	42.36-	.00	.00	01		77.64	30.00	
		DISCOUNT								45				
TOTAL		150.00		107.64		.00		30.00-				77.64		
		HEALTHCHOICE STATE OF OKLAHOMA												
SUB TOTAL		150.00		107.64		.00		30.00-				51.13		
PROVIDER TOTAL		150.00		107.64		.00		30.00-				51.13		

Note: Information included in this document is not part of an actual remit advice or overpayment notification letter and serves as a helpful guide to better understand this process.