RECOUPMENT REQUEST FORM

Use this form to submit a voluntary refund for overpayment.

Complete the form below. Send the form and your refund check to:
TriWest TRICARE West Region
Attn: Finance & Checks
P.O. Box 202162
Florence, SC 29502

Provider Tax Identification Number (TIN): ______________________________

Patient Name	Sponsor DBN	Claim #	Begin Date of Service	Reason for Refund	Overpaid Amount	Comments

For additional entries, please use the supplemental table on the next page and include with this completed form.

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