Select Health
of South Carolina, Inc.
An AmeriHealth Mercy Company

Provider Overpayment Worksheet

Provider Information

Provider Name _____ Tax ID# _____

NPI # _____ Today's Date _____

A copy of the primary insurance company's payment must accompany all refunds submitted for COB adjustment

Select Health Check Number	Select Health Check Amount	Select Health Claim #	Member Name	Date of Service	Select Health Paid Amount	Refund Amount
Comment/reason for refund:						
Comment/reason for refund:						
Comment/reason for refund:						
Comment/reason for refund:						
Comment/reason for refund:						
Comment/reason for refund:						
Comment/reason for refund:						
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