Overpayment Adjustment Request Form

Please use this form to request a recoupment from a future remittance or to send us a voluntary refund check for an overpayment we've made to you.

Provider Name	
Provider NPI	
Provider Address	
Phone	

If Lasso Healthcare is due a refund because of an overpayment made to you, please indicate your preference: recoupment (remittance credit) or voluntary refund of overpayment.

☐ Recoupment/credit on a future remittance (send this form to):

Lasso Healthcare MSA
P.O. Box 260925
Plano, TX 75026

☐ Voluntary refund of overpayment (send this form AND refund check to):

Lasso Healthcare MSA
P.O. Box 675174
Detroit, MI 48267-5174

Patient Name	
Lasso Healthcare ID Number	
Date(s) of Service	
Claim Number(s)	
Total Amount Overpaid	
Comments	

Please indicate reason for refund.

- ☐ Duplicate Payment
- ☐ Not our Patient
- ☐ Charges Billed in Error
- ☐ Other (explain) _____