Refund Form

Please include the check(s) to be refunded and a copy of the remittance notice.
Note: A separate form is required for each patient.

Contact Name:

Provider Name:

Address:

City: **State:** **ZIP:**

Tax Identification Number (TIN):

Phone Number:

Patient Name:

Date of Service:

Amount of Check:

Refund Check Number:

Check Date:

Subscriber Number:

Mail To:

☐ **WPS Health Insurance**
P.O. Box 7890
Madison, WI 53713

☐ **Aspirus Arise**
P.O. Box 7890
Madison, WI 53713

☐ **Arise Health Plan**
P.O. Box 7890
Madison, WI 53713

Note: Please make checks payable to the correct company.

Reason for Refund — Please check the reason for this refund:

☐ OHI/Medicare is primary ☐ Workers' compensation ☐ Duplicate payment
☐ Corrected claim ☐ Provider billed in error
☐ Other (please explain):

Please attach a copy of the primary payer EOB if applicable.

AspirusArise

Arise HEALTH PLAN

WPS HEALTH INSURANCE

 32087-100-1711