

Request for Resident Refund

Facility Name _____ Facility Number _____ Request Date _____

Resident Name _____ Resident Number _____
(please print)

Make check payable to: _____
(please print)

Facility Address _____

Admitted: _____
 Discharged: _____

Refund Type:
 Retroactive Medicaid _____ Overpayment _____
 Discharge _____ Other _____

PATIENT PAY TYPE	PAYING AGENCY	AMOUNT	BILL PERIOD

Reason for Refund _____

Administrator Signature _____ Date _____

Financial Consultant Signature _____ Date _____

Refund Requests exceeding \$500.00 require an additional approval signature based upon the refund amount.

Regional Vice President/Director _____ Date _____
 (\$500.00-\$2,500.00)

Senior Vice President of Operations _____ Date _____
 (\$2,500.00-\$50,000.00)

Verification by field accountant _____ Date _____

Check Amount \$ _____ Date of Issue _____

1. Attach both a copy of Resident History and the Resident Ledger to verify the balance of the requested amount.
2. Provide copies of supporting documentation, i.e., change of pay status, discharge information, proof of overpayment.
3. Send all originals to your Financial Consultant.
4. The Financial Consultant will forward approved requests and attachments to the Corporate Field Accounting department for requests less than \$500.00
5. The Financial Consultant will forward refund requests exceeding \$500.00 to the assigned Regional VP.
6. The Regional VP/Director will forward all Refund Requests to the Corporate Field Accounting department.
7. After the refund check has been returned to the facility, process the refund by entering an ADJUSTMENT in the A/R System. Attach refund request as documentation for the adjustment. Do not post the refund to the account until you have received the check copy and approved Refund Request form.
8. Facility will retain a copy of the approved refund request with a copy of check in the resident's file.