EMPOWER VOLUNTARY SELF-DISCLOSURE OF PROVIDER OVERPAYMENT

## Section 1: Provider Information

Complete the following fields as applicable. Alternate/Mailing Address is only required if you or your organization has a mailing address that differs from your service address.

Provider / Company Name:

Last name, First Name (If Individual Provider):

Provider Type:

Medicaid Provider ID:

National Provider Identifier (If Applicable):

Tax Identification Number (TIN):

License Number (If Applicable):

Address (Number and Street):

City, State, ZIP:

Office Telephone:

Email Address:

Alternate/Mailing Address (Number and Street):

City, State, ZIP:

## Section 2: Disclosure Details

Claims impacted:

| Claim # | Date of Service | Empower Member ID | Services impacted (Codes) | Dollars refunded |
|---|---|---|---|---|
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**(Additional lines available on next page if needed)**

## Section 2: Disclosure Details (Continued)

| Claim # | Date of Service | Empower Member ID | Services impacted (Codes) | Dollars refunded |
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## SECTION 3: REFUND EXPLANATION

Please explain in detail reason for overpayment for each claim indicated above:

| Claim # | Reason for overpayment |
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I am requesting that these funds be (choose one):

☐ Recouped by Empower ☐ Repaid by attached payment/check

## SECTION 4: SUBMISSION

- If you are attaching a check/payment to this form please mail this completed form, along with any payment to:

  ATTN: Empower – Overpayment
  Simmons Bank
  P.O. Box 8005
  Little Rock, AR 72203

- If you are requesting that funds be recouped or withheld from future payments, please submit this completed form to:

  ATTN: Empower – Claims Overpayment
  Empower Healthcare Solutions, LLC
  PO BOX 211446
  Eagan, MN 55121

| | |
|---|---|
| Signature of Submitter | Date (if not using digital signature) |