ASURIS
NORTHWEST HEALTH

Overpayment/Voucher Deduction Request

Submitted By_____ Provider Number_____ Date_____

We request that a deduction be made on our payment voucher for the following:

Patient Name_____ Patient Account Number_____

Patient Date of Birth_____ Service Dates_____

Subscriber ID Number ☐☐☐☐☐☐☐☐☐☐☐☐ Subscriber Name_____

Claim Number_____

Reasons for Deduction(s):

☐ Response to recoupment request

☐ Other Insurance Payment

Amount Paid: $_____ Patient Responsibility: $_____
(After Primary Carrier Payment)

Policy Holder_____ Policy Number_____

☐ Duplicate Payment

☐ Third Party Payment

☐ Late Credit

☐ Cancelled Charge

☐ Other (please specify)_____

Comments:

If Asuris has questions regarding this request, the person to contact at this provider's office is:

Name_____ E-mail Address_____

Phone Number_____ Best time to contact_____

Mail, Email or Fax request to:

Asuris TruAdvantage Claims	All Other Asuris Claims
Asuris Northwest Health Claims PO Box 1106 Lewiston, ID 83501 FAX: 1-888-335-2995	Asuris Northwest Health Plan PO Box 1106 Lewiston, ID 83501 Overpayment_Recovery@asuris.com FAX: 1-888-335-2995

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