ASURIS
NORTHWEST HEALTH

Please make check payable to:

ASURIS NORTHWEST HEALTH
PO BOX 3016
TACOMA WA 98401-3016

REFUND NOTIFICATION

Provider name:	
Address:	
Contact person:	
Phone number:	(xxx) xxx-xxxx

Patient name:			
Subscriber name:			
Patient ID / Group number:			
Patient account number:			
Date of service:	/ / 20	Claim number:	

Amount Refunded: $ _____

Reason for refund: (please check appropriate box)

☐	Not our patient
☐	Duplicate payment
☐	Other insurance primary
☐	Third party responsible (please explain)
☐	Other (please explain)

Please send separate checks for Asuris Northwest Health and Asuris TruAdvantage claims; and always attach a copy of the payment voucher, overpayment recovery request or other carrier's Explanation of Benefits.

Thank You