



Health Administration Center Champ VA Claim Overpayment Refund Form

* = required entry

Payer Information:

* Last Name: _____ * First Name: _____ M.I. _____

or
* Business Name: _____

* Address: _____

* City: _____

* State: * Zip Code: _____

* Telephone Number: _____

Payer Information:

* Name of Contact: _____

* Telephone Number: _____

Refund Information:

* VA Claim#	Bill of Collection#	* Beneficiary Name	* Date of Service (MM/DD/YYYY)	* Reason for Refund	* Payment Amount
_____	_____	_____	_____	<input type="text"/>	\$ _____
_____	_____	_____	_____	<input type="text"/>	\$ _____
_____	_____	_____	_____	<input type="text"/>	\$ _____
_____	_____	_____	_____	<input type="text"/>	\$ _____
_____	_____	_____	_____	<input type="text"/>	\$ _____
Total Payment Amount:					\$ 0 _____

Additional Information:

Submit Data