# Refund Form

**Please include the check(s) to be refunded and a copy of the remittance notice.**
**Note:** A separate form is required for each patient.

**Contact Name:**

**Provider Name:**

**Address:**

**City:** **State:** **ZIP:**

**Tax Identification Number (TIN):**

**Phone Number:**

**Patient Name:**

**Date of Service:**

**Amount of Check:**

**Refund Check Number:**

**Check Date:**

**Subscriber Number:**

**Mail To:**

☐ **WPS Health Insurance**
P.O. Box 8190
Madison, WI 53713

☐ **Aspirus Arise**
P.O. Box 8190
Madison, WI 53713

☐ **Arise Health Plan**
P.O. Box 8190
Madison, WI 53713

**Note:** Please make checks payable to the correct company.

**Reason for Refund—Please check the reason for this refund:**

☐ OHI/Medicare is primary ☐ Workers' compensation ☐ Duplicate payment
☐ Corrected claim ☐ Provider billed in error
☐ Other (please explain):

**Please attach a copy of the primary payer EOB if applicable.**

AspirusArise

Arise HEALTH PLAN

WPS HEALTH INSURANCE

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