



PacificSource Community Solutions, Inc.
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Contested Refund Form

If you believe that you have received an incorrect refund request, please fill out this form and return it to us. This form helps us identify the reason(s) why you are contesting the requested refund. You can find our contact information below. We must receive your contestation request within 30 days of the initial refund request.

Please type or print in ink.

Patient Information

Last Name	First	M.I.	Member ID#
Claim #	Date of Service	Provider Name	

Reason for review / Reconsideration

Please include supporting documentation such as chart notes or a letter of medical necessity, the primary carrier’s Explanation of Benefits (EOB), or a preapproval notice. Chart notes must be included for corrected diagnosis, date of service, patient information, procedure codes, and provider information.

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Corrected diagnosis | <input type="checkbox"/> Primary carrier’s EOB | <input type="checkbox"/> Preapproval |
| <input type="checkbox"/> Corrected date of service | <input type="checkbox"/> Corrected procedure code (CPT or CM) | |

Please note: Modifier changes require chart notes as well as an explanation. For example:
 Modifier 59—why do you feel this was a distinct and separately identifiable service?

Other: _____

Please attach a copy of the refund request letter, and list any clarifications or special instructions in the space below:

Please return this form to:

PacificSource Community Solutions, Inc.
 PO Box 7068
 Springfield, OR 97475
 Fax: (541) 322-6438