HealthChoice

MEMBER AUDIT FORM

If you think an error has been made on your bill and you wish to participate in the Member Audit Program, complete this form and mail it to HealthChoice, Attn: Compliance Department at 3545 N.W. 58th St., Suite 600 Oklahoma City, OK 73112. If you have any questions regarding the Member Audit Program, contact HealthChoice at 1-866-381-3815 or email at EGID.antifraud@omes.ok.gov.

NOTE: To qualify for a Member Audit Program award, all the following conditions must be met: The charges must be for services the member did not receive, or for overcharges or overpayments resulting from clerical error or miscalculation; the error must have impacted the actual benefit amount paid by at least $50.00; the member must report the error prior to detection and correction by the claims administrator to qualify.

Member Name: ______________________________

Address: ______________________________

SSN or Member ID: ______________________________

Patient Name: ______________________________

List the items that were overpaid on your account and attach documents to this form.

Date	Item	Amount
________	______________________	________
________	______________________	________

Reason(s) you believe these items were billed in error:

____

____

Provide the name and contact information of the person at the provider's office you reported these errors to:

Name: ______________________ Title: ____________

Provider Name: ______________________________

Address and Phone Number: ______________________________

Attach a copy of the corrected billing and any correspondence regarding this claim.

Member Signature: ______________________ Date: ____________