CLEAR FORM

Overpayment Adjustment Request Form

Please use this form to request a recoupment from a future remittance or to send us a voluntary refund check for an overpayment we've made to you.

Provider Name	
Provider NPI	
Provider Address	
Phone	

If Lasso Healthcare is due a refund because of an overpayment made to you, please indicate your preference: recoupment (remittance credit) or voluntary refund of overpayment.

☐ Recoupment/credit on a future remittance (send this form to address below)

Lasso Healthcare
225 West Washington St. Suite 450
Chicago, IL 60606

☐ Voluntary refund of overpayment (send this form AND refund check to address below)

Lasso Healthcare
Lockbox #235146
PO Box 85146
Chicago, IL 60689-5146

Patient Name	
Lasso Healthcare ID Number	
Date(s) of Service	
Claim Number(s)	
Total Amount Overpaid	
Comments	

Please indicate reason for refund.

☐ Duplicate Payment

☐ Not our Patient

☐ Charges Billed in Error

☐ Other (explain)