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 EDS Administration Services (EDS) at PO Box 24870, Oklahoma City, OK 73124-0870. If you have any questions regarding the member audit program, contact EDS at 1-405-416-1800 or 1-800-782-5218.

NOTE: HOSPITAL BILLS PROCESSED BY THE FLAT RATE DRG DO NOT QUALIFY FOR THE MEMBER AUDIT AWARD.

Member Name: ______________________________

Address: ______________________________

SSN or Member ID: ______________________________

Patient Name: ______________________________

Please list below the items which were overpaid on your accounts and attach documentation:

Date	Item	Amount

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

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Name of party, at the provider's office, to whom you reported these errors:

Name: ______________________________ Title: ______________________________

Provider Name: ______________________________

Address and Phone: ______________________________

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

Signature of Employee: ______________________________ Date: ______________

*** FOR OSEEGIB USE ONLY ***

The above mentioned billing error should be adjusted and the overpayment requested from the provider.
The signature below indicates that this claim qualifies for the Member Audit Award which should be issued to the member upon receipt of the overpayment.

Authorized Signature: ______________________________