CarePartners of Connecticut

Returned Funds Form

Complete all areas of this form and attach the payment Explanation of Payment (EOP) for the claims requesting to be refunded.

Today's date: _____

Provider name:	
Provider ID number:	
Contact name:	
Telephone number:	
Contact address:	

Check off all that apply:

☐ **I am returning a check to CarePartners of Connecticut**

Please indicate the Statement of Account (SOA) number and the claim number below:

SOA number _____

Claim number _____

☐ **I am writing a check to CarePartners of Connecticut**

Please indicate the Statement of Account (SOA) number and the claim number below:

SOA number _____

Claim number _____

☐ **I have enclosed a copy of the SOA**

Please explain why you are returning funds to CarePartners of Connecticut in the space below, e.g., claim billed in error, incorrect provider paid.

Mail form and attachments to:
CarePartners of Connecticut
Attn: Finance Operations
1 Wellness Way
Canton, MA 02021-1166