HealthChoice

MEMBER AUDIT PROGRAM 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: Program Integrity Unit, 2401 N. Lincoln Blvd., Ste. 300, Oklahoma City, OK 73105. If you have any questions regarding the Member Audit Program, call the HealthChoice Fraud, Waste and Abuse Hotline at 866-381-3815, email EGID.antifraud@omes.ok.gov or fax 405-717-8922.

To qualify for a Member Audit Program award, all following conditions must be met:

1. The charges must be for items/equipment or services the member did not receive, or for overcharges or overpayments resulting from clerical/provider billing errors or miscalculations.
2. The error must have impacted the actual benefit amount paid by at least $50.
3. 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 item(s)/services that were overpaid/paid in error on your account and attach any bills and/or correspondence regarding this claim to this form.

Date of service	Item/service	Provider	Billed charge(s)

Reason(s) you believe the item(s)/service(s) were billed in error:

_____

_____

Indicate the type of claim: Medical _____ Pharmacy _____ Dental _____

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 _____

Member signature _____ Date _____

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