

NCTracks PROVIDER REFUND FORM INSTRUCTIONS

- 1) Retrieve the most updated version of the refund form in the Provider Forms section of the [Provider Policies, Manuals, and Guidelines page](#) of the NCTracks website.
- 2) To help reduce questions, and ensure proper processing, please be certain that **ALL** of the information on the form has been entered before printing it.
- 3) Enter information for each claim by detail line. As entries are made into the form, the total refund amount will be calculated.
- 4) The sum of the entries must equal the amount of the refund check submitted with this form.
- 5) Print a copy of the completed Electronic Refund Form and submit the form and your refund check to the correct address below.
- 6) Only 1 Check **PER** NPI **PER** Payer (DMA/NCHC) combination. Please **do not** have multiple Payers or NPI's on the same refund check.

Addresses:

Misc Medicaid Payments PO Box 602885 Charlotte, NC 28260-2885	Misc NCHC Payments PO Box 602861 Charlotte, NC 28260-2861
Misc DPH Payments PO Box 602879 Charlotte, NC 28260-2879	Misc DMH Payments PO Box 602882 Charlotte, NC 28260-2882

Field	Description
TCN (NCTracks Claim ID Number)	Claim ID number assigned by NCTracks (15 digits)
Billing Provider Name	Name of Provider who billed the claim
Billing Provider Number	NPI of Provider who billed the claim
Recipient Full Name	Name of Recipient who received service
Recipient ID	Recipient ID number for Recipient – 9 digits, 1 letter
Dates of Service	Dates service was performed
Amount Billed	Detail billed amount
Amount Paid by DHHS	Detail amount paid by DHHS
Date DHHS Paid	Date of payment by DHHS
Amount of Refund	Amount which should be applied back to detail **Note : The total of this column must match the amount of the refund check
Reason for Refund	Reason the refund is being applied – select appropriate drop-down value

If you have any questions regarding this form or the refund process, please call **1-800-688-6696**.