Credit Balance Refund Data Sheet

WellSense HEALTH PLAN

Provider information (please print information clearly)				
Provider Payee name as shown on EOB		Provider Payee # as shown on EOB		
Contact Name	Title	Phone Number	Ext.	Fax Number
Email (we don't send PHI via unencrypted email)				

Providers should not submit refund checks for credit balance payments; instead, please contact us using the methods below and we will adjust your claim(s) and recover the credit balances through future payment offsets. This is a preferred method and ensures quicker turnaround time.

If you must send us a refund check because you can't submit a retraction request, please fill out check info below:

Check Issuer_____ Check No._____ Check Date _____Check Amount _____

Please submit the form by:

Upload to Health Trio online portal: please be sure to include the **Claim Review Form** in addition to the Credit Balance Refund Data Sheet and supporting documents.

Mail:
WellSense Health Plan
Attn: Credit Balance
100 City Square, Suite 200
Charlestown, MA 02129

Fax: 617-897-0811
Email: Credit.Balance@wellsense.org
For questions, please call 617-748-6229.

Patient information (please print clearly)				
Patient Name	Member ID	Patient Acct#	Date of service (DOS)	
Claim No.	Original payment# or check no.	Amount billed	Amount paid	Refund amt.

Last Updated 04/07/2025

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Please check one of the following reasons for refund:

☐	Billed in error
☐	Charges removed
☐	Cashed in error
☐	Duplicate payments
☐	TPL (Copy of Auto Insurance/WC payment required)
☐	COB (Copy of Primary Insurance EOB required)
☐	Other (please explain, e.g. list procedure code, service line) _____

Completed by _____ Date _____

Last Updated 04/07/2025