Rhode Island Executive Office of Health and Human Services
Medicaid Program
***Refund* Request**

ALL FIELDS ARE MANDATORY – ***if incomplete, the refund request form will be returned to the provider with a letter requesting additional information. Please note that all checks are deposited upon receipt.***

Provider Name_____ ***Contact Name***_____

Provider NPI_____ ***Contact Phone Number***_____

#	Recipient Name	MID #	ICN #	Detail # (If Applicable)	DOS	RA Date	Refund Amount	Refund Reason
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Mail to: DXC Technology PO Box 2010 Warwick, RI 02887