Proactive recoupment form

This form is for use by providers who have been overpaid and wish to return the additional funds. In order for us to properly apply your refund, please include the completed information request along with your refund check and send to:

TRICARE East Region
ATTN: Refunds/Recoupments
PO Box 7937
Madison, WI 53707-7937

Tax Identification #: _____

Patient name	Sponsor #	Claim #	Begin date of service	Reason for refund	Overpaid amount	Comments

For additional entries please see the supplemental table on the next page to include with this completed form.

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