HealthChoice
MEMBER AUDIT 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: Compliance Department at 3545 N.W. 58th St., Suite 600 Oklahoma City, OK 73112. If you have any questions regarding the Member Audit Program, contact HealthChoice at 1-866-381-3815 or email at EGID.antifraud@omes.ok.gov.

NOTE: To qualify for a Member Audit Program award, all the following conditions must be met: The charges must be for services the member did not receive, or for overcharges or overpayments resulting from clerical error or miscalculation; the error must have impacted the actual benefit amount paid by at least $50.00; 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 items that were overpaid on your account and attach documents to this form.

Date	Item	Amount
_____	_____	_____
_____	_____	_____

Reason(s) you believe these items were billed in error:

_____

_____

Provide the 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: _____

Attach a copy of the corrected billing and any correspondence regarding this claim.

Member Signature: _____ Date: _____