GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE
CREDIT BALANCE REPORT FORM

PROVIDER NAME:				**CONTACT PERSON:**			
PROVIDER NUMBER:				**TELEPHONE NUMBER (including area code):**			
QUARTER ENDING (circle or check one):	☐ 06/30	☐ 09/30	☐ 12/31	☐ 03/31	**YEAR:**		**PAGE _____ OF _____**

#	MEMBER NAME	MEDICAID ID NO	TCN	DATE(S) OF SERVICE	MEDICAID PAYMENT	COB PAYMENT	AMOUNT DUE TO MEDICAID	INSURANCE PLAN NAME; REFUND REASON *	POLICY NUMBER POLICYHOLDER NAME **
1									
2									
3									
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18									
19									
20									
TOTALS									

* IF CREDIT BALANCE NOT RELATED TO OTHER COVERAGE (COB), PROVIDE REFUND REASON.
** IF AVAILABLE, PLEASE ATTACH A COPY OF THE OTHER INSURANCE ID CARD TO THIS FORM.

☐ **NO REFUNDS IDENTIFIED**	**COMPLETED BY:**			
	TITLE:		**DATE:**	