## 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 |
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