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 asking for more 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								

R0062 V2.0 01/11/22 Mail to : Gainwell Technologies, P.O. Box 2010, Warwick, RI 02887