REFUND REQUEST FORM

Revised October 2026

Complete the form electronically using the legal provider name and Pay To address associated with the payment.
Apply the authorized signer digital signature and return the completed form by email or fax to PRSS. Required fields are marked with a red asterisk (*).

1. PROVIDER AND PAYMENT INFORMATION

Legal Provider Name * use the enrolled legal name

ATN * 10 digits, no dashes

NPI * 10 digits

Paid Amount * USD

Pay To Address Line 1 *

Pay To Address Line 2 optional

Pay To City *

State *

ZIP Code * 5 digits or ZIP+4

2. REFUND DETAILS

Provider Contact * name and best phone number or email

Reason for Refund * explain the refund and identify the related payment when applicable

3. AUTHORIZATION AND DIGITAL SIGNATURE

Enter the authorized signer information below, including only the last 4 digits of the SSN, then apply the digital signature.

Authorized Signer Name * printed name

Last 4 of SSN *

Date * MM/DD/YYYY

Authorized Signer Digital Signature *

CLICK OR TAP TO APPLY DIGITAL SIGNATURE

Digital signature instructions
Open this form in Adobe Acrobat or another compatible PDF application. Do not type a name in the field.