

Contractor Name:

Line of Business:

1	Recoupment Type (over 12 months; over \$100,000)	
2	How the need for recoupment was identified	
3	Reason for the recoupment including if systemic issue identified	
4	Corrective actions that the Contractor implemented to avoid future occurrences	
5	Method and process that will be utilized to recoup the funds	
6	Anticipated timeline for recoupment activities to be completed	
7	Total number of providers impacted	
8	Total number of claims (Must align with A.2)	
9	Dates of service date ranges (Must align with A.2)	
10	Total recoupment amount (Must align with A.2)	
11	Other recoupment action(s) specific to this provider within the contract year	
12	Confirm that drafted provider communication(s) are attached with deliverable submission	

ACOM POLICY 412 - ATTACHMENT A  
RECOUPMENT REQUEST  
**DRAFT**

	AHCCCS CLAIM NUMBER	AHCCCS MEMBER ID	PROVIDER NAME	PROVIDER TIN	BEGIN DATE OF SERVICES	END DATE OF SERVICE	DATE OF PAYMENT	HEALTH PLAN PAID AMOUNT	RECOUPMENT AMOUNT
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\$0.00      \$0.00