Provider Refund Remittance Form

TIN	NPI	Provider Name	Check Number

RID	MDwise Claim Number	Date of Service	Refund Amount	Full or Partial Refund	If Partial Refund CPT Code(s)	Reason for Refund

Mail the check and this form to:

*Only one TIN/NPI per form and check

MDwise, Inc.
PO Box 441423
Indianapolis, IN 46244-1423