PUBLIC EMPLOYEES INSURANCE AGENCY
PATIENT AUDIT PROGRAM

Employee Name:_____Policyholder ID:_____
Report is being made for: ☐ Self ☐ Spouse ☐ Dependent Child
Patient Name:_____
Address_____City:_____State_____Zip_____
Is the patient covered under other health insurance coverage? ☐ Yes ☐ No
If yes, complete the following: Policy Number:_____
Name of Insurance Company:_____
Name of Policyholder:_____

PLEASE ATTACH "EXPLANATION OF BENEFITS" FROM OTHER INSURANCE COMPANY

Have you ever filed a report through the Patient Audit Program? ☐ Yes ☐ No
What type of error have you identified? ☐ Billing Error ☐ Overpayment ☐ Services Not Received

NOTE: If you found errors in more than one explanation of benefits, please use a separate form for each one.

Please indicate the following regarding your contact with the hospital or provider:
Name of representative with whom you spoke:_____
Title:_____ Provider Name:_____
Address:_____ City:_____ State:_____Zip:_____
Date (s) of contact: ____/____/____ and ____/_____/_____ and _____/_____/_____ and _____/_____/_____
Please explain why you believe an errors exists, and if the provider does not agree, the reason for the disagreement:_____
_____
_____

I hereby authorize the above-named hospital/provider to release and provide any information relating to this error upon request of : PEIA, 805 or 96DUHPDUN

Employee Signature:_____ Date:_____

Home Telephone Number:_____ Work Telephone Number:_____

Enclose your explanation of benefits from PEIA and any other insurance company. Also include a detailed itemization of charges, a corrected bill, and an explanation of disagreement (if applicable). Mail your form and documents to:

Patient Audit Program Coordinator
Public Employees Insurance Agency
601 57th St., SE
Suite 2
Charleston, WV 25304-2345

Patient Audit form must be submitted within ninety (90) days from the date of payment by the Claims Administrator, otherwise, submission under the program is invalid.

In the event of an award in my favor, I authorize PEIA to use my name and likeness in promotions to increase public awareness of the Patient Audit Program.

Authorized Signature:_____ Date:_____
Revised □