BlueCross BlueShield of Texas

Please submit refunds to:
Blue Cross and Blue Shield of Texas
Refund and Recovery
Dept. 0695
PO Box 120695
Dallas, TX 75312-0695

# Provider Refund Form

| Provider Information: | |
|---|---|
| Name: | |
| Address: | |
| Contact Name: | |
| Phone Number: | |
| NPI Number: | |

**Refund Information:**

| 1 | Group # From PCS | Member I.D. From PCS | ADM Date | Claim/DCN # |
|---|---|---|---|---|
| | Patient's Name | Provider Patient # | Letter Reference # | Refund Amount: |
| | Reason/Remarks | | | |

| 2 | Group # From PCS | Member I.D. From PCS | ADM Date | Claim/DCN # |
|---|---|---|---|---|
| | Patient's Name | Provider Patient # | Letter Reference # | Refund Amount: |
| | Reason/Remarks | | | |

| 3 | Group # From PCS | Member I.D. From PCS | ADM Date | Claim/DCN # |
|---|---|---|---|---|
| | Patient's Name | Provider Patient # | Letter Reference # | Refund Amount: |
| | Reason/Remarks | | | |

| 4 | Group # From PCS | Member I.D. From PCS | ADM Date | Claim/DCN # |
|---|---|---|---|---|
| | Patient's Name | Provider Patient # | Letter Reference # | Refund Amount: |
| | Reason/Remarks | | | |

| 5 | Group # From PCS | Member I.D. From PCS | ADM Date | Claim/DCN # |
|---|---|---|---|---|
| | Patient's Name | Provider Patient # | Letter Reference # | Refund Amount: |
| | Reason/Remarks | | | |

| 6 | Group # From PCS | Member I.D. From PCS | ADM Date | Claim/DCN # |
|---|---|---|---|---|
| | Patient's Name | Provider Patient # | Letter Reference # | Refund Amount: |
| | Reason/Remarks | | | |

| Signature | Date | Check Number | Check Date |
|---|---|---|---|
| | | | |

# Refunds Due to Blue Cross Blue Shield

## 1) Key Points to check when completing this form:

| | |
|---|---|
| a) Group/Member Number: | Indicate the number exactly as they appear on the PCS (Provider Claim Summary) – including group and member's identification number |
| b) Admission Date: | Indicate the admission or outpatient service date as MMDDYY entry. |
| c) BCBS Claim/DCN #: | Indicate the BlueCross BlueShield Claim/DCN number as it appears on the PCS/EOB. Please do not use your provider patient number in this field. |
| d) Provider Patient #: | Indicate the Patient account number assigned by your office. |
| e) Letter Reference #: | **If applicable**, indicate the RFCR letter reference number located in the BlueCross BlueShield refund request letter. |

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   *** CLAIM INFORMATION ***

Patient Name : Cross Blue
Claim Number : 50****300020C
Group/ID No. : 55555-123456789
Service Dates: FROM 3/06/05 TO 3/06/05
Prov.Pat. No.:
Prov. Name   : Shield       Blue
Reference No.: J167503201
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| | |
|---|---|
| f) Check Number and Date: | Indicate the check number and date you are remitting for this refund. |
| g) Amount: | Enter the total amount refunded to BlueCross Blue Shield. |
| h) Remarks/Reason: | Indicate the reason as follows: |

| | |
|---|---|
| "C.O.B. Credit" | Payment has been received under two different Blue Cross memberships or from Blue Cross and another carrier. Indicate name, address, and amount paid by other carrier. |
| "Overpayment" | Blue Cross payment in excess of amount billed; provider has posted a credit for supplies or services not rendered; provider cancelled charge for any reason; or claim incorrectly paid per contract. |
| "Duplicate Payment" | A duplicate payment has been received from BlueCross for one instance of service (e.g. same group and member number). |
| "Not our Patient" | Payment has been received for a patient that did not receive services at this facility/treatment center. |
| "Medicare Eligible | Payment for the same service has been received from Blue Cross and the Duplicate Payment" Medicare intermediary. |
| "Workers Compensation" | Payment for the same service has been received from Blue Cross and a Workers' Compensation carrier. |

## 2) Mail the refund form along with your check to:

Blue Cross and Blue Shield of Texas
Dept. 0695
PO Box 120695
Dallas, TX 75312-0695