

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

Name				Prov	iaeri	nformatio	n:				
Name:											
Address:											
Contact Name:											
Phone Number:											
NPI	Number:										
	Refund Information:										
1	Group # From PCS	PCS Member I.D. From		PCS		ADM Date		Claim/DCN #			
	Patient's Name		Provider Patient #		nt#	Letter Referer		ce # Refund Amount:		ınd Amount:	
	Reason/Remarks										
2	Group # From PCS		Member I.D. From PCS		ADM Date		Claim/DCN #				
	Patient's Name		Provider Patien		it #		Letter Referen	ce # R		Refund Amount:	
	Reason/Remarks										
3	Group # From PCS		Member I.D. From PCS		ADM Date		Claim/DCN #				
	Patient's Name		Provider Patient #			Letter Referen	ce # Refu		und Amount:		
	Reason/Remarks										
4	Group # From PCS		Member I.D. From PCS		ADM Date		Claim/DCN #				
	Patient's Name		Provider Patien		nt #		Letter Reference #		Refund Amount:		
	Reason/Remarks										
5	Group # From PCS		Member I.D. From PCS		ADM Date		Claim/DCN #				
	Patient's Name		Provider Patien		it#		Letter Referen	ce #	Refu	und Amount:	
	Reason/Remarks										
6	Group # From PCS		Member I.D. From PCS		ADM Date			Claim/DCN #	CN #		
	Patient's Name		1	Provider Patier	vider Patient #		Letter Referen	ce#		efund 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.

*** 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

Service Dates: FROM 3/06/05 TO 3/06/0 Prov.Pat. No.: Prov. Name : Shield Blue Reference No.: J167503201

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