BlueCross BlueShield of Texas

Please submit refunds to:
Blue Cross and Blue Shield of Texas
PO Box 731431, Dallas, TX 75373-1431

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

BlueCross BlueShield of Texas

Refunds Due to Blue Cross Blue Shield

1) Key Points to check when completing this form:

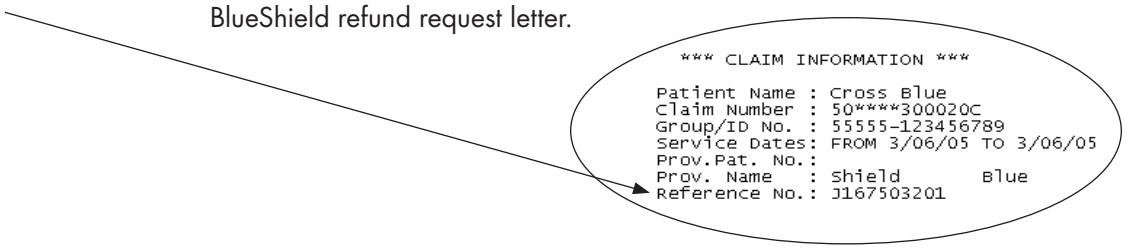
a) Group/Member Number: Indicate the number exactly as they appear on the PCS (Provider Claim Summary) – including group and member's identification number

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.



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 Duplicate Payment" Payment for the same service has been received from Blue Cross and the 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:

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PO Box 731431
Dallas, TX 75373-1431