

# Provider Refund Return



Please complete this form and include it when returning overpayments made payable to Blue Cross and Blue Shield of North Carolina. This will help us properly identify and credit the correct account and will assist in reducing the return of funds to your office.

Thank you for your cooperation.

Provider Name:

Provider Number:

If provider is outside of North Carolina, IRS Tax-ID Number:

Patient Name:

Date(s) of Service:

Subscriber Name:

Subscriber ID:   
(include prefix and dependent code)

Check One:

- ☐ Blue Cross and Blue Shield of NC Plan
- ☐ Blue Cross Blue Shield Service Benefit Plan (Federal Employee Program)
- ☐ North Carolina Teachers and State Employee's Health Plan
- ☐ Other Health Plan:

Amount of Refund:

Please check reason(s) for Refund:

- ☐ Duplicate Payment (submit both Blue Cross and Blue Shield of North Carolina vouchers)
- ☐ Worker's Compensation (give date of onset of injury/sickness):
- ☐ Medicare payment is primary (submit Medicare EOB)
- ☐ Other carrier paid primary (submit other carrier's EOB)
- ☐ Corrected claim/billed in error (submit copy of corrected claim)
- ☐ Filed under wrong patient (submit copy of corrected claim)
- ☐ Incorrect date of service (submit corrected claim)
- ☐ Medicare adjusted payment (submit EOB)
- ☐ Other Carrier adjusted payment (submit EOB)
- ☐ Not our patient

Please include the applicable BCBSNC Explanation of Payment or Notification of Payment with this form.

Other Comments:

Contact Person:

Phone Number:

**Return to:** Financial Processing Services  
Blue Cross and Blue Shield of North Carolina  
PO Box 30048  
Durham, NC 27702-3048

