BlueCross BlueShield of Illinois

Provider Refund Form

Please submit refunds to:
BlueCross and BlueShield of Illinois
PO Box 805107 Zip code 60680-4112

Provider Information:

Name:

Address:

Contact Name:

Phone Number:

Provider Number: NPI Number:

Refund Information:

1	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			
2	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			
3	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			
4	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			
5	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			
6	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			

SIGNATURE	DATE	CHECK NUMBER	CHECK DATE

Refunds Due to BlueCross BlueShield

1) Key Points to check when completing this form:

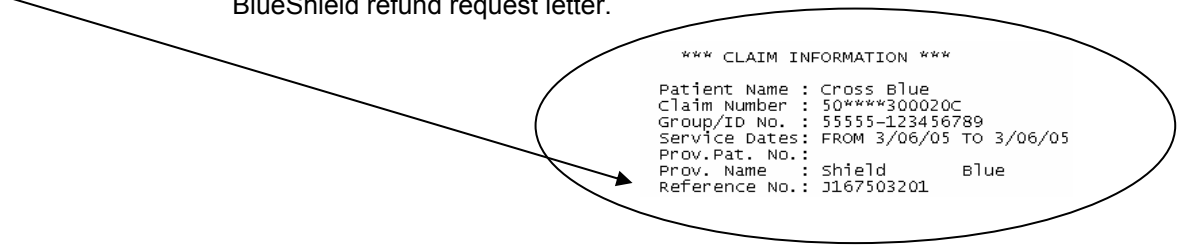
a) Group/Member Number: Indicate the number exactly as they appear on the PCS (Provider Claim Summary) - including group and member's identification number

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 BlueShield.

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:

Blue Cross Blue Shield of Illinois
Cash Receipts Department
PO Box 805107
Chicago, IL 60680-4112