

Provider Refund Form

Please submit refunds to:
Blue Cross and Blue Shield of Texas
Attn: Refund Department/Cash Disbursement
P.O. Box 650776, Dallas, TX 75265-9598

Provider Information

Name: _____

Address: _____

Contact Name: _____

Phone Number: _____

National Provider Identifier (NPI) Number(s): _____

Refund Information

1 | Group Number: _____ Subscriber I.D. Number _____

Service Date: _____ Claim Number: _____

Refund Amount: _____ Patient Name: _____

Explanation: _____

INTERNAL USE ONLY Account: _____ Reason: _____ System: _____

2 | Group Number: _____ Subscriber I.D. Number _____

Service Date: _____ Claim Number: _____

Refund Amount: _____ Patient Name: _____

Explanation: _____

INTERNAL USE ONLY Account: _____ Reason: _____ System: _____

3 | Group Number: _____ Subscriber I.D. Number _____

Service Date: _____ Claim Number: _____

Refund Amount: _____ Patient Name: _____

Explanation: _____

INTERNAL USE ONLY Account: _____ Reason: _____ System: _____

4 | Group Number: _____ Subscriber I.D. Number _____

Service Date: _____ Claim Number: _____

Refund Amount: _____ Patient Name: _____

Explanation: _____

INTERNAL USE ONLY Account: _____ Reason: _____ System: _____

5 | Group Number: _____ Subscriber I.D. Number _____

Service Date: _____ Claim Number: _____

Refund Amount: _____ Patient Name: _____

Explanation: _____

INTERNAL USE ONLY Account: _____ Reason: _____ System: _____