

# 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):

BCBSTX Provider Number or Tax ID Number:

## 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: \_\_\_\_\_