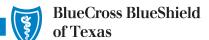


Please submit refunds to: **Claims Refund for Medicaid** Blue Cross and Blue Shield of Texas Claims Overpayments Dept. CH 14212 Palatine, IL 60055-4212 Please submit refunds to: **Courier Address (signature required)** Blue Cross and Blue Shield of Texas Claims Overpayments Box 14212 5505 North Cumberland Ave., Ste 307 Chicago, IL 60656-1471

Provider Refund Form

			Prov	ider I	nformatior	1:		
Name:								
Address:								
Contact Name:								
Phone Number:								
NPI	Number:							
	Member Number		Refu	und Ir	formation:		al Number) #	
1	Patient's Name	Patient Account #			Claim/DCN (Document Control Number) # # Refund Amount:			
		Patient Account						
	Reason/Remarks							
2	Member Number	ber Number			Claim/DCN #			
	Patient's Name	me Patient.			#		Refund Amount:	
	Reason/Remarks	/Remarks						
	Member Number	Number			Claim/DCN #			
3	Patient's Name	Patient Account #			# Refund Amount:			
	Reason/Remarks	leason/Remarks						
4	Member Number				Claim/DCN #			
	Patient's Name	Patient Account -			F Refund Amount:			
	Reason/Remarks							
5	Member Number	nber Number			Claim/DCN #			
	Patient's Name	Patient Account :			#		Refund Amount:	
	Reason/Remarks							
6	Member Number				Claim/DCN #			
	Patient's Name	Patient Account			e Refund Amount:			
	Reason/Remarks						T	
Signature				Date		Check Numbe	er	Check Date



Refunds Due to Blue Cross and Blue Shield of Texas

1) Key Points to check when completing this form:

a) Member Number:	Indicate the member's number					
b) Claim/DCN #:	Indicate the Blue Cross and Blue Shield of Texas Claim/DCN number as it appears on the Provider Claims Summary (PCS) / Explanation of Benefits (EOB). Please do not use your patient account number in this field.					
c) Patient Account #:	Indicate the patient account number assigned by your office.					
d)Check Numberand Date:	Indicate the check number and date you are remitting for this refund.					
e) Amount:	Enter the total amount refunded to Blue Cross and Blue Shield of Texas.					
f) Remarks/Reason:	Indicate the reason as follows: (this is not an all-inclusive list)					
	"C.O.B. Credit"	Payment has been received under two different Blue Cross and Blue Shield of Texas memberships or from Blue Cross and Blue Shield of Texas and other carrier. Indicate name, address and amount paid by other carrier.				
	"Overpayment"	Blue Cross and Blue Shield of Texas 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 Blue Cross and Blue Shield of Texas for one instance of service (e.g. same group and member number).				
	"Not our Patient"	Payment has been received for a patient who did not receive services at this facility/treatment center.				
	"Medicare Eligible"	Payment for the same service has been received from Blue Cross and Blue Shield of Texas and the "Duplicate Payment" Medicare intermediary.				
	"Workers Compensation"	Payment for the same service has been received from Blue Cross and Blue Shield of Texas and a Workers' Compensation carrier.				

2) Mail the refund form along with your check to:

Claims Refund for Medicaid Blue Cross and Blue Shield of Texas Claims Overpayments Dept. CH 14212 Palatine, IL 60055-4212	Courier Address (signature required) Blue Cross and Blue Shield of Texas Claims Overpayments Box 14212 5505 North Cumberland Ave., Ste 307
	Chicago, IL 60656-1471