BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross Blue Shield Association

VOLUNTARY OVERPAYMENT RETURN FORM

Blue Cross Legacy #

Refund Information

Provider Name	Individual NPI *(National Provider Identifier)*
Organizational NPI (Payer) *(if applicable)*	Tax ID Number –
Office Address	
City / State / Zip / County	
Mailing Address	
City / State / Zip / County	
Person to contact *(if necessary)* within above named provider's office	Office Phone / Fax Number

Patient Information

Patient Name	Patient Acct. #	
Contract Number	Group Number	Sex ☐ Male ☐ Female

Claim Number	Remit Date	Amount	Date of Service
Total Amount *(check one)* ☐ Deduct ☐ Enclosed $	Approved by		Date

Reason for refund adjustment

☐ Not our patient ☐ Corrected billing ☐ Incorrect provider ☐ Charges / Claims submitted in error ☐ Worker's compensation

☐ Duplicate payment – Original claim number _____

☐ Medicare Primary – Medicare number _____

☐ Other insurance primary – Other insurance information _____

☐ Subrogation/Auto-Insurance – Company _____

☐ Insured _____

☐ Other (Please specify) _____

I certify this information is complete and correct to the best of my knowledge.

_____ Signature

_____ Title

_____ Date

Submission Instructions

EMAIL the signed and completed form to **PaymentProcessing@bcbsal.org**	**FAX** the signed and completed form to Payment Processing: **205-220-7401**	**MAIL** the signed and completed form to **Blue Cross and Blue Shield of Alabama**, Attn: Payment Processing, Post Office Box 360899, Birmingham, AL 35236-0899