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 |
|---|---|---|---|

| Person to contact *(if neccesary)* 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

**UPLOAD** The signed and completed form to the Payment & Refund>Refund Billing>Voluntary Overpayment Form
**https://providers.bcbsal.org/portal/**

**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

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