



# VOLUNTARY OVERPAYMENT RETURN

Please check **only one** and refer to the mailing addresses at the bottom of this form. This refund concerns claim(s) for:

- Blue Cross and Blue Shield       NASCO

## REFUND INFORMATION

Provider Name		Location ID / NPI Number		Tax ID Number	
Person to contact (if necessary) within above named provider's office			Telephone Number (    )		Extension
Patient Name (one patient per form, please)			Patient Account Number		Patient Contract Number
CLAIM NUMBER		REMIT DATE		AMOUNT	
DATE OF SERVICE					
<b>TOTAL AMOUNT:</b> <i>(check one)</i>		<input type="checkbox"/> DEDUCT		\$	
		<input type="checkbox"/> ENCLOSED		Approved by	
				Date	

## REASON FOR REFUND ADJUSTMENT

<input type="checkbox"/> DUPLICATE PAYMENT – ORIGINAL CLAIM NUMBER _____
<input type="checkbox"/> NOT OUR PATIENT
<input type="checkbox"/> CORRECTED BILLING
<input type="checkbox"/> MEDICARE PRIMARY – MEDICARE NUMBER _____
<input type="checkbox"/> OTHER INSURANCE PRIMARY – OTHER INSURANCE INFORMATION _____
<input type="checkbox"/> WORKER'S COMPENSATION
<input type="checkbox"/> AUTO INSURANCE – COMPANY _____
<input type="checkbox"/> INSURED _____
<input type="checkbox"/> OTHER (please explain) _____
<input type="checkbox"/> INCORRECT PROVIDER
<input type="checkbox"/> CHARGES/CLAIMS SUBMITTED IN ERROR

## MAILING ADDRESS

<p>Blue Cross and Blue Shield of Alabama ATTENTION: PAYMENT PROCESSING PO Box 360899 Birmingham, AL 35236-0899</p>
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