BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

VOLUNTARY OVERPAYMENT RETURN FORM

Check one please.

☐ Blue Cross and Blue Shield of Alabama ☐ NASCO

Refund Information

Provider Name	Individual NPI *(National Provider Identifier)*
Organizational NPI *(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		Group Number
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 ☐ Subrogation ☐ Worker's compensation

☐ Duplicate payment – Original claim number _____

☐ Medicare Primary – Medicare number _____

☐ Other insurance primary – Other insurance information _____

☐ 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

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