



PROVIDER REFUND RETURN

Please complete this form when returning overpayments to the Blue Cross and Blue Shield of North Carolina. This will help us properly identify and credit the correct certificate and will assist in reducing the return of funds to your office.

Thank you for your cooperation.

Check One:

Subscriber Name: _____ Blue Cross and Blue Shield of NC plan

Subscriber ID: (prefix) _____ Blue Cross and Blue Shield Service Benefit Plan
(Federal Employee Program)

North Carolina Teachers & State Employees'
Health Plan

Other Health Plan (Specify): _____

Patient Name: _____ Date(s) of Service: _____

Provider Name: _____ Provider Number: _____

If provider is outside of North Carolina, IRS Tax-ID Number: _____

Amount of Refund: _____

Please check reason(s) for Refund:

- Duplicate Payment (submit need both Blue Cross and Blue Shield of North Carolina vouchers)
- Worker's Compensation (Give date of onset of injury/sickness): _____
- Medicare payment is Primary (submit Medicare EOB)
- Other carrier paid primary (submit other carrier's EOB)
- Corrected claim/billed in error (submit copy of corrected claim)
- Filed under wrong patient (submit copy of corrected claim)
- Incorrect date of service (submit corrected claim)
- Medicare adjusted payment (submit EOB)
- Other carrier adjusted payment (submit EOB)
- Not our patient

Please include the applicable BCBSNC Explanation of Payment or Notification of Payment with this form.

Other Comments: _____

Return to: _____

Financial Processing Services
Blue Cross and Blue Shield of North Carolina
PO Box 30048
Durham, NC 27702-3048

Contact Person: _____
Phone Number: _____