

INTER-PLAN PROGRAMS PAR / HOST PLAN

Please use this form as a checklist to insure that you are submitting the information necessary to support a returned claim payment (*refund*) for an out-of-area member's claim. Providing this information will allow BCBSNC to more effectively represent your interest when communicating with the patient's Home Plan.

1. Break down of the refund per claim

2. Provide the Explanation of Benefits (EOB) documentation for all insurance carriers associated with the claim. Insure that the EOB documentation details the following items:

- a. Provider's name _____
- b. Provider's BCBSNC ID number _____
- c. Policy Holder's full name _____
- d. Policy Holder's ID (*include prefix and number*) _____
- e. Patient's full name _____
- f. Patient's date of birth _____
- g. Date of Service _____
- h. Amount of charge for the original claim _____
- i. Amount paid for the original claim _____
- j. Date of payment for the original claim _____
- k. Amount being returned against the original charge _____

3. Specific reason for the refund

- a. Duplicate Payment (*requires both BCBSNC vouchers*)
- b. Worker's Compensation (*provide the date of the onset*) _____
- c. Medicare payment is primary (*requires EOB*)
- d. Other carrier paid primary (*requires EOB*)
- e. Corrected claim / billed in error (*need a copy of the claim*)
- f. Filed under wrong patient (*requires a copy of the claim*)
- g. Incorrect date of service (*requires a corrected claim*)
- h. Medicare adjusted payment (*requires EOB*)
- i. Other carrier adjusted payment (*requires EOB*)
- j. Not our patient

Please return the check and all attached information to:

Blue Cross Blue Shield of North Carolina
ATTN: Cashiers Department
PO Box 30048
Durham, NC 27702-3048

4. Provide Corrected Claim Form (*if necessary*)

5. If this is a rebuttal to a payment issue previously raised to BCBSNC, please attach a copy of the information described above, as well as a copy of the BCBSNC check voucher to the check.

6. Provide the following support documentation (*if available*)

- a. Original Claim Number or Copy of the Original Claim
- b. Original Notification of Payment (NOP)

Again as the Host Plan, BCBSNC requests that you submit one check per claim. Organizing this information in this manner will allow BCBSNC to affectively represent you the provider as we engage the Home Plan or National Account to resolve payment contention issues for which they were originally held responsible for.

Thank you in advance for providing the necessary information and attaching it to the check to be sent to BCBSNC.

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