BlueCross BlueShield of Texas

Please submit refunds to:
Claims Refund for Medicaid
Blue Cross and Blue Shield of Texas
Claims Overpayments
Dept. CH 14212
Palatine, IL 60055-4212

Please submit refunds to:
Courier Address (signature required)
Blue Cross and Blue Shield of Texas
Claims Overpayments
Box 14212
5505 North Cumberland Ave., Ste 307
Chicago, IL 60656-1471

Provider Refund Form

Provider Information:	
Name:	
Address:	
Contact Name:	
Phone Number:	
NPI Number:	

Refund Information:

1	Member Number	Claim/DCN (Document Control Number) #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		
2	Member Number	Claim/DCN #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		
3	Member Number	Claim/DCN #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		
4	Member Number	Claim/DCN #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		
5	Member Number	Claim/DCN #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		
6	Member Number	Claim/DCN #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		

Signature	Date	Check Number	Check Date

BlueCross BlueShield of Texas

Refunds Due to Blue Cross and Blue Shield of Texas

1) Key Points to check when completing this form:

a) Member Number: Indicate the member's number

b) Claim/DCN #: Indicate the Blue Cross and Blue Shield of Texas Claim/DCN number as it appears on the Provider Claims Summary (PCS) / Explanation of Benefits (EOB). Please do not use your patient account number in this field.

c) Patient Account #: Indicate the patient account number assigned by your office.

d) Check Number and Date: Indicate the check number and date you are remitting for this refund.

e) Amount: Enter the total amount refunded to Blue Cross and Blue Shield of Texas.

f) Remarks/Reason: Indicate the reason as follows: **(this is not an all-inclusive list)**

"C.O.B. Credit"	Payment has been received under two different Blue Cross and Blue Shield of Texas memberships or from Blue Cross and Blue Shield of Texas and other carrier. Indicate name, address and amount paid by other carrier.
"Overpayment"	Blue Cross and Blue Shield of Texas payment in excess of amount billed; provider has posted a credit for supplies or services not rendered; provider cancelled charge for any reason; or claim incorrectly paid per contract.
"Duplicate Payment"	A duplicate payment has been received from Blue Cross and Blue Shield of Texas for one instance of service (e.g. same group and member number).
"Not our Patient"	Payment has been received for a patient who did not receive services at this facility/treatment center.
"Medicare Eligible"	Payment for the same service has been received from Blue Cross and Blue Shield of Texas and the "Duplicate Payment" Medicare intermediary.
"Workers Compensation"	Payment for the same service has been received from Blue Cross and Blue Shield of Texas and a Workers' Compensation carrier.

2) Mail the refund form along with your check to:

Claims Refund for Medicaid
Blue Cross and Blue Shield of Texas
Claims Overpayments
Dept. CH 14212
Palatine, IL 60055-4212

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