BlueCross BlueShield of Texas

Provider Refund Form

If you've identified a claims overpayment from Blue Cross and Blue Shield of Montana and want to submit a refund to us, **see page 2 for instructions on what to include** to support your request and ensure timely processing. Specify the **reason for the request** using one of the descriptions on page 2.

Quick tip: Electronic options are available to simplify the overpayment reconciliation process. Rather than printing and mailing this form, we encourage you to use our Electronic Refund Management tool. Questions? Email our eRM Onboarding team.

Provider Information

Name:	National Provider Identifier:
Address:	
Contact Name:	Phone Number:

Refund Information

1	Group Number from Provider Claim Summary:	Member ID From PCS:	Service Date:	Claim Number/Document Control Number:
	Patient's Name:	Provider's Patient Number:	Letter Reference Number:	Refund Amount:
	Check Number (from BCBSTX):		Check Issue Date:	
	Reason/Remarks:			
2	Group Number from PCS:	Member ID From PCS:	Service Date:	Claim Number/DCN:
	Patient's Name:	Provider's Patient Number:	Letter Reference Number:	Refund Amount:
	Check Number (from BCBSTX):		Check Issue Date:	
	Reason/Remarks:			
3	Group Number from PCS:	Member ID From PCS:	Service Date:	Claim Number/DCN:
	Patient's Name:	Provider's Patient Number:	Letter Reference Number:	Refund Amount:
	Check Number (from BCBSTX):		Check Issue Date:	
	Reason/Remarks:			
4	Group Number from PCS:	Member ID From PCS:	Service Date:	Claim Number/DCN:
	Patient's Name:	Provider's Patient Number:	Letter Reference Number:	Refund Amount:
	Check Number (from BCBSTX):		Check Issue Date:	
	Reason/Remarks:			
5	Group Number from PCS:	Member ID From PCS:	Service Date:	Claim Number/DCN:
	Patient's Name:	Provider's Patient Number:	Letter Reference Number:	Refund Amount:
	Check Number (from BCBSTX):		Check Issue Date:	
	Reason/Remarks:			

Signature:	Date:	Your Check Number:	Check Date:

Instructions	
Follow these tips when completing the fields on the paper Provider Refund Form:	
Group/Member ID Number	Include the member's group and identification number exactly as they appear on your provider claim summary from BCBSTX.
Service Date	Enter the service date as MMDDYY.
Claim Number/DCN	Indicate the Claim Number/DCN as it appears on your PCS from BCBSTX. Do not use your provider patient number in this field.
Check Number (from BCBSTX)	Enter the number of the check you received from BCBSTX as it appears on the PCS.
Patient Name	Include the first and last name of the patient for whom services were rendered by your office.
Letter Reference Number	**If applicable**, indicate the Request For Claim Refund reference number from the RFCR letter you received from BCBSTX.
Your Check Number/Check Date	Enter the check number for your refund payment and date of remittance.
Amount	Enter the total amount refunded to BCBSTX.
Remarks/Reason	**Specify the reason for the refund using one of the remarks/descriptions below.** A specific reason and all supporting documentation must be included for proper review. If your request is missing any required information, we'll return it to you to resubmit. **"Overpayment" is not a valid refund reason.** • **"C.O.B."** – A Coordination of Benefits credit payment was received under two different Blue Cross and Blue Shield memberships or from BCBS and another carrier. (Include a copy of the other carrier's Explanation of Benefits. Do not use for Medicare or Third Party Liability, such as Workers' Compensation.) • **"Corrected Claim"** – Payment received for charges that has been corrected. (Include the corrected claim number and/or copy of the corrected claim.) • **"Duplicate Payment"** – A duplicate payment has been received from BCBSTX for one instance of service (e.g., same group and member number). (Include the duplicate claim number and/or explanation of benefits for duplicate payment. Do not use for COB, Medicare, Workers' Compensation or Third Party Liability.) • **"Not Our Patient"** – Payment has been received for a patient who did not receive services at this facility/treatment center. • **"Pricing"** – The payment from BCBSTX is more than the provider's contracted rate. (Include detail of expected reimbursement.) • **"Medicare"** – Medicare has paid primary or reprocessed and payment from BCBSTX has exceeded the Medicare patient liability. (Include a copy of Medicare's explanation of benefits.) • **"Third Party Liability"** – Payment for the same service was received from BCBSTX and a third party liability carrier (e.g., auto, commercial liability). (Include a copy of the carrier's explanation of benefits.) • **"Workers' Compensation"** – Payment for the same service has been received from BCBSTX and a Workers' Compensation carrier. • **"Billing Error"*** – [This remark may apply if the provider has posted a credit for supplies or services not rendered; or if the provider canceled charge(s) for any reason. You must indicate if all charges were canceled or indicate the specific charges canceled for partial refund. ***This option should not be used if one of the other options applies.**]
Mailing Address	
Send your completed form, supporting documentation and refund check to:	Blue Cross and Blue Shield of Texas Dept. 0695 PO Box 120695 Dallas, TX 75312-0695