BlueCross BlueShield Nebraska

Provider Check Return Form

Form must be returned with check

To process a claim adjustment, please complete this form and send along with a check. If this form is received without a check or if a check is received without this form, the adjustment may not be processed and the funds may be returned to you. If you have additional documentation, please include it.

Send completed form and check to: Blue Cross and Blue Shield of Nebraska
PO Box 30112
Omaha, NE 68103-1212

Provider Name:			Tax ID Number:
Patient Name: (ONE patient per form)		Patient Date of Birth:	Patient BCBS ID Number: (Include alpha prefix)

Reason Number (from the list below)	Claim Number	Date of Service From	To	Amount Overpaid	Remittance Advice Date	Patient Account Number

TOTAL AMOUNT BEING REFUNDED FOR THIS PATIENT: $ ☐

REASON(S) FOR REFUND/OVERPAYMENT:

☐ 1. Duplicate payment - *Original Claim Number* : _____

☐ 2. Not our patient

☐ 3. Incorrect provider - *Correct Provider Number or Tax ID Number* : _____

☐ 4. Corrected billing - *Attached corrected claim(s).*

☐ 5. Charges submitted in error - *Provide details* : _____

☐ 6. Medicare primary - *Medicare Number* : _____ *Attach a copy of the MEOB.*

☐ 7. Medicare adjustment - *Attach corrected claim(s) and a copy of the MEOB.*

☐ 8. Rental vs. purchase

☐ 9. Other health insurance primary: *Attach other insurance information or a copy of the EOB/Remit.*

☐ 10. Paid by Workers' Compensation

☐ 11. Paid by other third party - *Third party information* : _____

☐ 12. Two BCBS policies paid as primary - *Other ID Number* (include alpha prefix) : _____

☐ 13. Other - *Please explain*: _____

_____

_____

_____

Provider Contact Person Name: _____

Contact Person Phone and/or Email: _____

Signature: _____ Date: _____

Please keep a copy of the completed form for your documentation.

For questions or assistance call Provider Services at 402-390-1890 or 800-642-8516.