



PO Box 21501
Eagan, MN 55121

Provider Refund/Overpayment Request

*Required Fields

Provider Information								
Name*:	Tax ID*:	NPI*:						
Contact Name*:	Phone Number* (including area code):							
For Checks, attach and mail this form to: Blue Cross and Blue Shield Nebraska Attn: Medicare Advantage P.O. Box 3248 Omaha, NE 68180	For Offsets, mail this form to: Blue Cross and Blue Shield Nebraska P.O. Box 21501 Eagan, MN 55121							
Member/Patient Information								
BCBSNE Member	Out of State Member							
Member Name*:	Member ID* (including alpha prefix)							
Total Check Amount*:	Check Number*:							
Claims/Overpayment Information Using this form authorizes an automatic offset and you will not receive additional notification before the offset is processed.								
Overpayment reason* <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Claim Overpayment</td> <td style="width: 50%; border: none;">Duplicate</td> </tr> <tr> <td style="border: none;">Void Claim or Charges</td> <td style="border: none;">Not our Patient</td> </tr> <tr> <td style="border: none;">Other:</td> <td style="border: none;"></td> </tr> </table>			Claim Overpayment	Duplicate	Void Claim or Charges	Not our Patient	Other:	
Claim Overpayment	Duplicate							
Void Claim or Charges	Not our Patient							
Other:								
Enter Claim details. List up to 5 claims for the same patient								
Claim Number*:	Date of Service*:	Refund Amount*:						
Claim Number*:	Date of Service*:	Refund Amount*:						
Claim Number*:	Date of Service*:	Refund Amount*:						
Claim Number*:	Date of Service*:	Refund Amount*:						
Claim Number*:	Date of Service*:	Refund Amount*:						

If you have questions or need further assistance with completing this form, please call Provider Inquiry at 1-888-505-2022

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