Provider Refund Return

This form serves as a remittance advice to assist in properly adjusting your account/claim with either Blue Cross NC or the NC State Health Plan. Please use one form per claim, complete the form in its entirety and include with your payment. This will help us properly identify and credit the funds appropriately and will prevent us from returning your payment. Make checks payable to Blue Cross NC or the State Health Plan, depending on which company paid the claim.

Billing Provider Name:

Billing National Provider Identifier:

Billing Provider Tax ID Number:

Claim Number:

Subscriber ID Number:
(include prefix)

Date of Service(s):

Subscriber Name:

Patient Name:

Check(s) or EFT(s) Number:

Check(s) or EFT(s) Date:

Amount of Refund:

Please check reason(s) for the refund:

- ☐ Duplicate Payment (submit both EOPs)
- ☐ Worker's Compensation (give injury/sickness onset date or submit Dept of Labor Letter)
- ☐ Medicare primary/Medicare adjusted payment (submit Medicare EOB)
- ☐ Other insurance primary/Other insurance adjusted payment (submit other insurance EOB)
- ☐ Corrected claim (submit copy of corrected claim & add reason in Comments field)
- ☐ Not our patient
- ☐ Other (add details in the comments below)

Comments:

Please include all relevant supporting documentation with this form.

Contact Person:

Contact Phone Number:

Contact Email:

Return to:
Financial Processing Services
Blue Cross NC
PO Box 30048
Durham, NC 27702-3048