BlueCross BlueShield of North Carolina MEDICARE

Provider Authorization Form: Claims Adjustments and Offsets

Please note, this form applies to Healthy Blue + Medicare℠ (HMO D-SNP) offered by Blue Cross and Blue Shield of North Carolina.

Please submit this completed authorization form with all supporting documentation to ensure proper processing of your request to adjust claims as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

Provider Information
Provider name:
Provider NPI:
Provider TIN:
Provider contact information:
Cost Containment Unit project number (if applicable):
Document identification number (if applicable):
Total recoupment dollar amount:

Please list claim information below if the Cost Containment Unit letter or other supporting claim and/or member detail is not provided with this request:

Claim Information			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

https://www.bluecrossnc.com/providers/blue-medicare-providers/healthy-blue-medicare

BNCCARE-0146-21 June 2021 519143NCPENABS

Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			

If your request for recoupment exceeds the space provided, please attach an Excel file that includes all of the data noted above. If you have questions related to the completion of this form, please call Provider Services at **844-895-8160**.

I authorize Blue Cross and Blue Shield of North Carolina to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

_____ _____

Print name Signature

Return this form via:

Mail:
Blue Cross and Blue Shield of North Carolina
Attn: Cost Containment — Disputes
P.O. Box 62427
Virginia Beach, VA 23466-2437

Fax: **866-920-1874**

Note: Do not use this form if you are submitting a refund check. If you would like to submit a refund, please use the *Overpayment Refund Notification Form* on our website at **https://www.bluecrossnc.com/providers/blue-medicare-providers/healthy-blue-medicare**. Mail a check along with the supporting documentation to:

Blue Cross and Blue Shield of North Carolina
Attn: Cost Containment — Payments
P.O. Box 933657
Atlanta, GA 31193-3657