Provider Refund Submission Form

CareFirst
Family of health care plans

INSTRUCTIONS

This form should be used anytime you are submitting a refund to CareFirst BlueCross BlueShield and/or CareFirst BlueChoice.

1. Use a separate form for each member included on the enclosed refund check.
2. Include the entire subscriber identification number, including the prefix.
3. Attach a copy of the original provider voucher, along with any additional information that might assist in processing the enclosed refund.
4. Send this completed form to PO Box 789747, Philadelphia, PA 19178-9747

Important: Before issuing a refund, please verify that the accounts receivable reflected on your provider voucher has not already been satisfied.

Corrected Claims: This form should not be used for a refund as the result of a corrected claim. Please follow the instructions for submitting a corrected claim.

INFORMATION

Provider/Practice Name and Address	Date
Provider National Provider Identifier (NPI)	Claim #*
Prefix and Subscriber ID#*	Date of Service
Patient Name	Patient Account #
Patient Date of Birth	Refund Amount

REASON FOR REFUND

- ◯ Billed in error
- ◯ Returned product (DME/Supplies)
- ◯ COB (If other insurance is primary, please attach the primary EOB)
- ◯ Subrogation/Worker's compensation (please attach document from carrier)
- ◯ Not our Patient
- ◯ Processed under wrong NPI (be sure to include correct NPI above)
- ◯ Other _____

ADDITIONAL COMMENTS

CONTACT INFORMATION

Contact Person	Contact Telephone	Contact Email

*Indicates required field

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