BlueCross BlueShield of New Mexico

Please submit refunds to:
Blue Cross and Blue Shield of New Mexico
Refund and Recovery
Dept. 0695
PO Box 120695
Dallas, TX 75312-0695

Provider Refund Form

Provider Information:	
Name:	
Address:	
Contact Name:	
Phone Number:	
NPI Number:	

Refund Information:

1	Group # From PCS	Member I.D. From PCS	ADM Date	Claim/DCN #
	Patient's Name	Provider Patient #	Letter Reference #	Refund Amount:
	Reason/Remarks			
2	Group # From PCS	Member I.D. From PCS	ADM Date	Claim/DCN #
	Patient's Name	Provider Patient #	Letter Reference #	Refund Amount:
	Reason/Remarks			
3	Group # From PCS	Member I.D. From PCS	ADM Date	Claim/DCN #
	Patient's Name	Provider Patient #	Letter Reference #	Refund Amount:
	Reason/Remarks			
4	Group # From PCS	Member I.D. From PCS	ADM Date	Claim/DCN #
	Patient's Name	Provider Patient #	Letter Reference #	Refund Amount:
	Reason/Remarks			
5	Group # From PCS	Member I.D. From PCS	ADM Date	Claim/DCN #
	Patient's Name	Provider Patient #	Letter Reference #	Refund Amount:
	Reason/Remarks			
6	Group # From PCS	Member I.D. From PCS	ADM Date	Claim/DCN #
	Patient's Name	Provider Patient #	Letter Reference #	Refund Amount:
	Reason/Remarks			

Signature	Date	Check Number	Check Date

Refunds Due to Blue Cross Blue Shield

1) Key Points to check when completing this form:

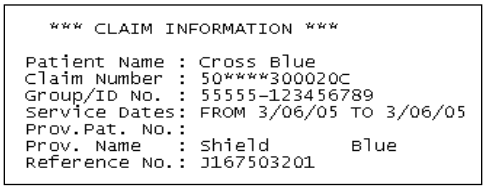
a) Group/Member Number: Indicate the number exactly as they appear on the PCS (Provider Claim Summary) – including group and member's identification number

b) Admission Date: Indicate the admission or outpatient service date as MMDDYY entry.

c) BCBS Claim/DCN #: Indicate the BlueCross BlueShield Claim/DCN number as it appears on the PCS/EOB. Please do not use your provider patient number in this field.

d) Provider Patient #: Indicate the Patient account number assigned by your office.

e) Letter Reference #: **If applicable**, indicate the RFCR letter reference number located in the BlueCross BlueShield refund request letter.



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   *** CLAIM INFORMATION ***

Patient Name : Cross Blue
Claim Number : 50****300020C
Group/ID No. : 55555-123456789
Service Dates: FROM 3/06/05 TO 3/06/05
Prov.Pat. No.:
Prov. Name   : Shield       Blue
Reference No.: J167503201
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f) Check Number and Date: Indicate the check number and date you are remitting for this refund.

g) Amount: Enter the total amount refunded to BlueCross Blue Shield.

h) Remarks/Reason: Indicate the reason as follows:

"C.O.B. Credit"	Payment has been received under two different Blue Cross memberships or from Blue Cross and another carrier. Indicate name, address, and amount paid by other carrier.
"Overpayment"	Blue Cross payment in excess of amount billed; provider has posted a credit for supplies or services not rendered; provider cancelled charge for any reason; or claim incorrectly paid per contract.
"Duplicate Payment"	A duplicate payment has been received from BlueCross for one instance of service (e.g. same group and member number).
"Not our Patient"	Payment has been received for a patient that did not receive services at this facility/treatment center.
"Medicare Eligible	Payment for the same service has been received from Blue Cross and the Duplicate Payment" Medicare intermediary.
"Workers Compensation"	Payment for the same service has been received from Blue Cross and a Workers' Compensation carrier.

2) Mail the refund form along with your check to:

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PO Box 120695
Dallas, TX 75312-0695