



INDEPENDENCE BLUE CROSS OVERPAYMENT / REFUND FORM

Date: _____ Provider Number: _____

Provider Name: _____

Provider Address: _____

<p>For Provider Use Only</p> <p>Contact Person at Provider's Office:</p> <p>_____</p> <p>Telephone Number: _____</p>

Member ID / Name	Date(s) of Service	Claim Number	Remit Amount

Reason for Refund:	Type of Refund:
<input type="checkbox"/> Payment of Outstanding Credit Balance / AR <input type="checkbox"/> Duplicate Payment <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Medicare <input type="checkbox"/> Other Insurance _____ <input type="checkbox"/> Provider Billing Error <input type="checkbox"/> Processing Error <input type="checkbox"/> Unable to Identify Patient <input type="checkbox"/> Multiple Payments (if multiple members are affected, check box and attach a copy of your Statement of Remittance with names highlighted.)	<input type="checkbox"/> Medical Claim <input type="checkbox"/> Capitation <input type="checkbox"/> Other _____

Comments: _____

Providing patient information enables us to credit your account in a timely manner. Please return a copy of the Statement of Remittance with this request.

Please submit to: IBC Claims Overpayment
 P. O. Box 18683
 Newark, NJ 07191-8683

The preferred, more expedient method for handling overpayment/refund issues is through the claims adjudication process in which credits and/or retractions will automatically appear in your next Statement of Remittance. To request these adjustments, or if you have any questions, please call Provider Services at 1-800-ASK- BLUE or 1-800-275-2583 for assistance.

Thank you for your cooperation.