

# BLUECROSS BLUESHIELD OF SOUTH CAROLINA OVERPAYMENT REFUND FORM

Use this form when sending BlueCross BlueShield of South Carolina unsolicited/voluntary refund checks:

<b>To Be Completed by BlueCross BlueShield of South Carolina</b>	
Date:	
Provider Deposit Control Number:	Date of Deposit:
Provider Contact Name:	Phone Number:
Provider Address:	
Provider Fax Number:	
<b>To Be Completed by Provider/Physician/Supplier</b>	
Please complete and forward to BlueCross BlueShield of South Carolina at the address below. This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.	
Provider Name:	
Address:	
Tax ID Number:	Check Number:
Contact Person:	Phone Number:
Amount of Check:	Check Date:
<b>Refund Information</b>	
<i>For each claim, provide the following:</i>	
Patient Name:	ID Number:
Claim Number:	Claim Amount Refunded:
Reason for Code Claim Adjustment: _____ (Select reason from list below. Use one reason per claim.) <i>(Please list all claim numbers involved. Attach a separate sheet, if necessary.)</i>	
Note: If specific Patient/ ID Number/ Claim Number/ Claim Amount data is not available for all claims due to Statistical Sampling, indicate method and formula used to determine amount and reason for overpayment:	
For Institutional Facilities Only:	
Cost Report Year(s): (If multiple years are involved, provide a breakdown by amount and corresponding cost report year.)	
For OIG Reporting Requirements:	
Do you have a Corporate Integrity Agreement with OIG? (check one) <span style="float: right;">Yes      No</span>	
<b>Reason Codes:</b>	
<b>Billing/Clerical Error</b> 01 – Corrected Date of Service 02 – Duplicate payment 03 – Corrected Code 04 – Not Our Patient(s) 05 – Modifier Added/Removed 06 – Billed in Error 07 – Incorrect Patient(s)	<b>MSP/Other Payer Involvement</b> 08 – Other Commercial Carrier Primary 09 – Medicare Primary
<b>Miscellaneous</b> 10 – Services not rendered 11 – Other (Please Specify)	

**Mail this form with your check to:**

**BlueCross BlueShield of South Carolina  
Attn: Lockbox, AX-A31  
I-20 E at Alpine Road  
Columbia, SC 29219-0001**

Enter text directly into this document by placing your cursor on the blanks. Click on boxes to select them, or tab to them and press your spacebar. To delete all answers, select the Clear Form button at the left. Print and mail to us to complete.