Refund Check Information Form

Empire BlueCross BlueShield

Please fill out this form when sending in a refund check. Be sure to submit your correspondence to the Provider Service address indicated on your Explanation of Benefits (EOB). To ensure timely and accurate processing of your refund check, please provide the following information:

Patient name _____
Member/Policy holder name _____
Identification number _____
Claim number _____
Date of service(s) _____
Amount of refund _____

The above information is required. We cannot accept a refund without the information above.

Reason for refund

_____ Not our patient

_____ Billed in error

_____ Incorrect provider

_____ Duplicate payment

_____ Worker comp

_____ No fault

_____ *Paid prime should be secondary to Medicare coverage
(If available, attach a copy of the Medicare HIB card)

_____ Paid prime should be secondary to another insurance carrier
(If checked, fill out below)

Other carrier's name _____
Contract or policy number _____
Effective date with other carrier _____
Policy holder's name _____
Policy holder's employer _____

Other *(please explain)* _____
_____
_____
_____
_____

*If a refund check was requested by us, please include a copy of the letter.
*If EOB (Explanation of Benefits) is available, please attache and return along with this form and explanation.

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