



Refund Form

Use this form when sending BlueChoice HealthPlan unsolicited/voluntary refund checks. To ensure proper routing of refunds, please complete this form and attach the check and a copy of the remittance advice. Forward to the address listed below:

To Be Completed by Physician's Office

Tax ID Number:	
Provider's Name:	
Provider's Address:	
Provider's Phone Number:	
Contact's Name:	
Check Number:	
Check Date:	
Amount of Check:	

Refund Information

Patient's Name:	
Patient's ID Number:	
Claim Number:	
Claim Amount Refunded:	

Reason for Refund

Choose the appropriate refund reason or use space provided for explanation

- | | |
|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Corrected Date of Service | <input type="checkbox"/> Incorrect Patient Filed |
| <input type="checkbox"/> Duplicate Payment | <input type="checkbox"/> Services Not Rendered |
| <input type="checkbox"/> Corrected Code | <input type="checkbox"/> Member Has Primary Insurance
<small>Insurance Company Name _____ (attach EOB)</small> |
| <input type="checkbox"/> Not Your Patient | <input type="checkbox"/> Billed in Error |
| <input type="checkbox"/> Modifier Added/Removed | |

Other: _____

Mail this form with check and remit to:

**BlueChoice HealthPlan
 Refunds Department (AX-430)
 P. O. Box 6170
 Columbia, SC 29260-6170**