BlueChoice HealthPlan
South Carolina
An independent licensee of the Blue Cross and Blue Shield Association

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

_____ Corrected Date of Service

_____ Duplicate Payment

_____ Corrected Code

_____ Not Your Patient

_____ Modifier Added/Removed

_____ Incorrect Patient Filed

_____ Services Not Rendered

_____ Member Has Primary Insurance
Insurance Company Name _____ (attach EOB)

_____ Billed in Error

Other: _____

_____

_____

Mail this form with check and remit to:

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

6/2009