Clear Form

TO: CLAIMS REFUND DEPARTMENT

REFUND TYPE:

- **[ ] Arkansas Blue Cross and Blue Shield - including BlueCard**
- **[ ] Federal Employee Program - ABCBS**
- **[ ] BlueAdvantage Administrators of Arkansas**
- **[ ] USAble Administrators**
- **[ ] USAble Life Group Health**
- **[ ] Health Advantage**
- **[ ] Medicare Services**

THE FOLLOWING INFORMATION IS NEEDED IN ORDER TO PROCESS YOUR REFUND IF A COPY OF THE REMITTANCE ADVICE IS NOT AVAILABLE.

(1) reason for the refund_____

(2) patient name_____

(3) patient ID number_____

(4) claim number or BlueCard SCCF #_____

(5) date of service_____

(6) amount_____

(7) provider name (pay to)_____

(8) provider number (pay to)_____

(9) and TIN (pay to)_____

NOTE: It is not necessary to return the original check and the entire remittance advice/explanation of payment if just one or two patient claims are paid incorrectly. Please enclose copies of the remittance advice/explanation of payment pages with the claims paid in error highlighted and a notation of the reason for the refund.