

## Refund Form

Use this form when sending Healthy Blue 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<br>Insurance Company Name _____ (attach EOB) |
| <input type="checkbox"/> Not Your Patient          | <input type="checkbox"/> Billed in Error   |
| <input type="checkbox"/> Modifier Added/Removed    |  |

Other:

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**Mail this form with check and remit to:**

**Healthy Blue  
Refunds Department (AX-480)  
P. O. Box 100317  
Columbia, SC 29202-3317**