Empire BlueCross BlueShield

An Anthem Company

Overpayment refund notification form

In order for an overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is an Empire BlueCross BlueShield HealthPlus (Empire) check, please include a completed form specifying the reason for the check return.

Provider name/contact _____

Contact number _____

Provider ID _____

Provider Tax ID _____

Subscriber ID _____

DCN number (displayed on Cost Containment Unit letter) _____

Member name _____

Member account number _____

Date of service (to) _____

Total billed charges $_____

Total check amount: $_____

Claim number(s):

Reason for refund or check return:

□ Empire letter
□ Contract rate change
□ Duplicate payment
□ Incorrect member
□ Incorrect provider
□ Negative balance
□ Other health insurance/third-party liability
□ Payment error
□ Billed in error/adjusted charge
□ Other: _____

All refund checks should be mailed with a copy of this form to:
Empire BlueCross BlueShield HealthPlus
P.O. Box 933657
Atlanta, GA 31193-3657

Once the Empire Containment Unit has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this overpayment refund notification form.

Important Note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

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