TO:

BlueCross BlueShield of Vermont
P.O. BOX 186
MONTPELIER, VT 05601-0186
An Independent Licensee of the Blue Cross and Blue Shield Association

PROVIDER OVERPAYMENT FORM
TEL. (802) 223-6131

SHADED SECTION TO BE COMPLETED BY PROVIDER

FROM: _____

_____

_____

REASON FOR RETURN:

- ☐ INCORRECT CHARGE BILLED
- ☐ NOT OUR PATIENT
- ☐ CHARGES BILLED IN ERROR
- ☐ DUPLICATE PAYMENT (SAME CERT NO.)
- ☐ OTHER (EXPLAIN UNDER COMMENTS)

PROVIDER NO.	
NAME	DATE
PHONE NO.	EXT.

PLEASE TAKE A	OVER PAYMENT OF
$ CREDIT	$ ENCLOSED

PATIENT NAME	
MEDICAL RECORD NO.	CERTIFICATE NO.
DATE(S) OF SERVICE	
TOTAL CHARGE	$ PAID BY BLUE CROSS BLUE SHIELD OF VERMONT
$ PAID BY OTHER INSURER	BLUE CROSS BLUE SHIELD OF VERMONT PAY DATE

OTHER CARRIER PAYMENT, WHAT TYPE

- ☐ WORKERS' COMPENSATION
- ☐ THIRD PARTY LIABILITY (ie: AUTO ACCIDENT)
- ☐ OTHER HEALTH INSURANCE (COB)
- ☐ MEDICARE

NAME & ADDRESS OF INSURANCE CO.

_____

_____

_____

NOTE: PLEASE ATTACH A COPY OF MEDICARE / OTHER INSURANCE EXPLANATION OF BENEFIT.

TYPE OF PAYMENT:

- ☐ BLUE CROSS
- ☐ BLUE SHIELD
- ☐ MAJOR MEDICAL
- ☐ COMPREHENSIVE
- ☐ MANAGED CARE
- ☐ NATIONAL ACCOUNT
- ☐ FEDERAL EMPLOYEE PROGRAM (FEP)
- ☐ MEDI-COMP
- ☐ WORKERS COMP
- ☐ STATE OF VT CHOICE PLUS

COMMENTS

SIGNATURE	PHONE NO.	EXT.	DATE

TO BE COMPLETED BY BLUE CROSS BLUE SHIELD OF VERMONT

- ☐ A CREDIT OF $ _____ WILL BE TAKEN IN A FUTURE PAYMENT
- ☐ A CREDIT CANNOT BE TAKEN. PLEASE FORWARD CASH REFUND OF $ _____ TO MY ATTENTION.
- ☐ WE ARE UNABLE TO LOCATE THIS PAYMENT. PLEASE FORWARD COPIES OF THE REMITTANCE ADVICES IN QUESTION.
- ☐ PLEASE REFUND $ _____ TO THE SUBSCRIBER/OTHER INSURANCE.
- ☐ OTHER (EXPLANATION) _____

_____

SIGNATURE	PHONE NO.	EXT.	DATE

CREDITS ARE PREFERABLE, BUT PAYMENTS ARE ACCEPTABLE.

PROVIDER - COMPLETE GRAY SHADED AREA
1. DETACH LAST COPY 2. FORWARD FIRST TWO COPIES.

BLUE CROSS BLUE SHIELD OF VERMONT - COMPLETE WHITE SECTION
1. DETACH TOP COPY 2. FORWARD YELLOW TO PROVIDER