REFUND OF MONIES



PLEASE REMIT TO: Cash Processing • Capital Blue Cross • PO Box 773301 • Harrisburg, PA 17177-3301

Please be sure to include this form along with your remittance amount. If possible, please attach a copy of the corresponding **Statement of Remittance**. Providing patient information enables us to credit your account in a more efficient and timely manner.

Provider Group Na	me		Provider Group ID Number Date		
Provider Mailing Address City State				State ZIP Code	
* Total Remitted Amount	Claim Amount	HRA Aı	nount]	
	Capital Blue Cross Check Number		Blue Cross er ID Number	Claim Number/ SOR Control Number	
Patient Name		Patient Account N	umber	Date of Service	
Practitioner ID Number		Practitioner Name	Practitioner Name		
*A refund for the total amount of the claim specified above is required. Adjustment of the entire transaction is necessary to					
ensure accurate posting of the member's financial responsibility. Please do not remit an adjusted amount.					
Downant Error Occurred for the Following Pagen(s)					
Payment Error Occurred for the Following Reason(s): Unable to identify patient					
Provider Billing					
Explanation:					
Duplicate Payment					
Explanation:					
Other					
Explanation:					
Other Insurance Liability:					
☐ Workers' Compensation ☐ Motor Vehicle Related					
	Security sm /Senior sm HIC Numb	per			
	Other Insurer				

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