Blue Cross complete of Michigan

Provider Claim Refund Form

Your satisfaction is important to us. To ensure your refund is processed expeditiously, we request that you fully complete the Provider Refund Claim Form. The form enables us to credit your account in a timely manner. If your refund contains more than one claim, please complete the attached form or attach your own file listing the required data elements.

Provider information		
Date:	Provider name:	
NPI:	TIN:	Blue Cross Complete provider ID:
Provider address:		
Office contact:		Phone number:

Member information				
Member name	Blue Cross Complete member ID	Date of service	Claim number	Refund amount

Please note: If your refund contains more than one claim, please used the attached form (page 2) or attach your own file.

Type of refund	
☐ Medical overpayment	☐ Capitation
Other:	

Reason for refund	
☐ Other insurance (attach primary EOB)	☐ Subrogation
☐ Duplicate payment	☐ Claim was processed under the incorrect provider
☐ Incorrect provider cashed check	☐ Not our check
☐ Billing error	☐ Contract change or fee schedule update
☐ Eligibility	☐ Recovery project (please include project letter)
☐ Incentive payment	☐ Return supplies (durable medical equipment)
☐ Other (Please provide details. “Overpayment” is not a valid reason.)	

All checks should be made payable to Blue Cross Complete of Michigan and sent to:

Blue Cross Complete of Michigan
Attn: Provider Refunds
P.O. Box 7355
London, KY 40742

Additional Claim Form

If your refund contains more than one claim, please complete this form or attach your own file listing the required data elements below.

Member name	Blue Cross Complete member ID	Date of service	Claim number	Refund amount	Reasons for claim
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Print form

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