

## 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 Anthem Blue Cross and Blue Shield Medicaid (Anthem) check, please include a completed form specifying the reason for the check return.

<b>Provider name/contact</b> _____
<b>Contact number</b> _____
<b>Provider ID</b> _____
<b>Provider Tax ID</b> _____
<b>Subscriber ID</b> _____
<b>DCN number (displayed on Cost Containment Unit letter)</b> _____
<b>Member name</b> _____
<b>Member account number</b> _____
<b>Date of service (to)</b> _____
<b>Total billed charge \$</b> _____

**Total check amount \$** \_\_\_\_\_

**Claim number(s):**


**Reason for refund or check return:**

- Anthem 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:

**Anthem Blue Cross and Blue Shield Medicaid**  
**P.O. Box 933657**  
**Atlanta, GA 31193-3657**

Once the Anthem Cost 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.

**[www.Anthem.com/KYMedicaiddoc](http://www.Anthem.com/KYMedicaiddoc)**