

Provider Authorization to Adjust Claims and Create Claim Offsets

Please submit this completed authorization form with all supporting documentation to ensure proper processing of your request to adjust claims as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

Provider name:	
Provider NPI:	
Provider tax identification number:	
Provider contact information:	

Cost Containment project number (if applicable):	
Document identification number (if applicable):	
Total recoupment dollar amount:	

Please list claim information below if the Cost Containment letter or other supporting claim/member detail is not provided with this request.

Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			

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Recoupment reason:			

If your request for recoupment exceeds the space provided, please attach an Excel file that includes all the data noted above. For questions related to the completion of this form, please call Provider Services at **1-844-396-2330**.

I authorize Anthem Blue Cross and Blue Shield Healthcare Solutions to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

Print name

Signature

Mail this form to:

Anthem Blue Cross and Blue Shield Healthcare Solutions
 Cost Containment — Disputes
 P.O. Box 62427
 Virginia Beach, VA 23466-2437

Note: Do not use this form if you are submitting a refund check. To submit a refund, please use the refund notification form on our website at **<https://mediproviders.anthem.com/nv>**.

Mail a check along with the supporting documentation to:

Anthem Blue Cross and Blue Shield Healthcare Solutions
 Cost Containment — Payments
 P.O. Box 933657
 Atlanta, GA 31193-3657