



**NOTICE OF EXCESS PAYMENT/OVERPAYMENT**

Please do not send any payment (cash, check, money order, etc.) with this form.

**CONTRACT / PATIENT INFORMATION**

Member ID number \_\_\_\_\_ Group number \_\_\_\_\_  
Member name \_\_\_\_\_  
Plan code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Patient name \_\_\_\_\_  
Patient account number \_\_\_\_\_

**CLAIM TO BE RECOUPED**

**REASON FOR RECOUPMENT**

Remit / EOB date \_\_\_\_\_

(Check one box and provide information as indicated)

Amount overpaid \_\_\_\_\_  
(Generally, BCBSAZ will not recover amounts less than \$35.00)

Another carrier paid (Attach copy of EOB)

Claim number (ICN) \_\_\_\_\_

Worker's Comp. paid (Attach copy of EOB)

Date(s) of service:

Duplicate payment (Attach copy of remit/EOB)

From \_\_\_\_\_

Corrected billing (Attach corrected billing with all corrections clearly circled)

To \_\_\_\_\_

Unable to identify patient

Total charge \_\_\_\_\_

Other (Enter a detailed explanation below)

Amount paid \_\_\_\_\_

**Time Limit Waiver:** Provider agrees that BCBSAZ may recoup this excessive payment notwithstanding any time limits that would otherwise apply.

Provider name \_\_\_\_\_

Provider NPI number \_\_\_\_\_

**ADDITIONAL EXPLANATION**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

Mailing address \_\_\_\_\_

Telephone number \_\_\_\_\_

Fax number \_\_\_\_\_

Date \_\_\_\_\_

Prepared by \_\_\_\_\_

## Guidelines for Blue Cross Blue Shield of Arizona (BCBSAZ) Notice of Excess Payment Form

1. Use for any overpayment identified. **Please do not send any payment (cash, check, money order, etc.) with this form.**
2. Complete a separate form for each claim to be recouped and attach legible copies of all related remits/EOBs. Any required information that does not appear, or is illegible on the remit/EOB must be entered on the form. If unable to provide a remit/EOB copy, all of the required information must be entered on the form.
3. Address form(s) to: Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
4. Guide for individual fields:
  - **Contract/Patient Information** (The subscriber/member number and name are always required)
    - **Member Number:** Enter the patient's Blue Cross Blue Shield ID number exactly as shown on the identification card. Include any alpha prefixes.
    - **Member Name:** Enter the name that the Blue Cross Blue Shield contract is listed under. Complete any of the following lines for which information is not on the remit/EOB or is illegible, or all lines if remit/EOB copy is not attached.
    - **Group Number:** Enter the patient's Blue Cross Blue Shield group number exactly as shown on the ID card. For a patient in the Federal Employee Program (FEP), enter FEP and the 3-digit enrollment code.
    - **Plan Code:** If the patient is a member of an out-of-state plan, but BCBSAZ processed the claim, enter the 3-digit plan code, city and state.
    - **Patient Name:** Enter the patient's first name, middle initial and last name. In the case of a female patient, always use her given name. For example: Mary J. Johnson, not Mrs. M.J. Johnson or Mrs. John Johnson.
    - **Patient Account Number:** If you enter your patient's account number in this space, we will show this number on your remittance advice.

■ **Claim Information (for claim to be recouped)** (The remit/EOB date and amount overpaid are always required.)

- **Remit/EOB Date:** Enter the date that BCBSAZ made payment.
- **Amount Overpaid:** Enter the amount overpaid by BCBSAZ.

Complete any of the following lines for which information is not on the remit/EOB or is illegible, or all lines if remit/EOB copy is not attached.

- **Claim Number (ICN):** Enter the ICN.
- **Date(s) of Service:** Enter the beginning and ending date(s) of service(s).
- **Total Charge:** Enter the total charge.
- **Amount Paid:** Enter the total payment made by BCBSAZ.
- **Provider NPI Number:** Enter the NPI number under which claim was processed.
- **Provider Name:** Enter name under which claim was processed.

■ **Reason for Recoupment (check appropriate box)**

- **Another Carrier Paid** – Attach a copy of other carrier's EOB.
- **Worker's Comp Paid** – Attach a copy of Workers' Compensation EOB.
- **Duplicate Payment (for claim processed correctly)** – Attach a copy of remit/EOB
- **Corrected Billing** – Attach a corrected billing with all corrections/changes clearly circled.
- **Unable to identify patient** – Attach a copy of the remit/EOB
- **Other** – Enter a detailed explanation under "Additional Explanation."

- **Time Limit Waiver:** There may be a time limit on recoupment provided either by law or your network participation agreement. Check this box if you agree to waive any applicable time limits.

■ **Additional Explanation**

- This field should be used whenever you can provide any pertinent information, in addition to that which is required, that will assist us in processing the recoupment.
- Name, mailing address, telephone number, fax number, date, prepared by – complete all lines.

5. Attach any additional information to support your request.