



Think You Have An Overpayment?

BLUECROSS BLUESHIELD OF TENNESSEE OVERPAYMENT NOTIFICATION FORM

Please complete this form in its entirety. If our review of submitted claim(s) show an overpayment has been made, we'll recover the overpayment(s) through an offset on your future remittance advice.

*****Please note that CORRECTED CLAIMS should be submitted electronically, not submitted using this form.*****

Provider Name: _____

Provider ID #: _____ Patient Account #: _____

Patient Name: _____

Member ID #: _____ Date of Service: _____

Claim #: _____

Reason for Overpayment: _____

Estimated Overpayment Amount: \$ _____

If your overpayment is related to Coordination of Benefits, please provide the following information:

Primary Carrier's Name: _____

Policy ID#: _____ Policy Holder: _____

Policy Effective Date: _____ Policy Term Date: _____

****Submit a copy of the other insurance carrier's remittance advice along with this request, if available.****

If your overpayment is related to Subrogation or Workers' Compensation, please provide the following information:

Other Carrier's Name: _____

Policy or Claim ID#: _____ Policy Holder: _____

Amount Received from other Carrier: \$ _____

****Submit a copy of the other insurance carrier's Remittance Advice along with this request if available.****

Please fax this form to the appropriate number below, along with any documents showing the overpayment:

BlueCare/TennCareSelect: 1-866-504-6356

BlueCard: (423) 535-1959

CoverKids: 1-866-636-0085

Dental: (423) 535-3205

BlueCare Plus HMO DSNP: 1-888-725-6849

BlueAdvantage: (423) 535-5498

Federal Employees Program (FEP): (423) 535-7917

All Other Lines of Business: (423) 591-9080

Subrogation/Workers' Compensation: (423) 591-9444

Provider Contact Information:

Contact Name: _____

Contact Phone #: _____ Extension: _____

Email Address: _____

Fax #: _____