Anthem

ANTHEM BLUE CROSS AND BLUE SHIELD PROVIDER INQUIRY/REFUND/ADJUSTMENT FORM

Date:_____ ☐ **Underpayment** ☐**Overpayment** ☐ **Corrected Claim** ☐ **Unknown Type of Inquiry**
☐ Physician ☐Facility ☐Dental ☐Vision

Identification Number	Member Name	Patient Name	Patient Account No.
Claim No.	Serv. Date/Adm. Date _____	Billed Amount	

Provider Tax ID No. _____ **Anthem Provider No**._____ **NPI**_____ **Office Contact Name** _____

Provider Name_____ **Phone No**. _____ **Fax No**. _____

Remit Address:_____

Section 1 *Check box that best describes reason for adjustment:*

☐ **Late Charges** (Fill out Section 2). *Note: Late charges can be submitted electronically using the ANSI X12 837 claim format.*

☐ **Workers Compensation/Subrogation** (Attach EOB) ☐ Accident Date _____

☐**Diagnosis Change** ☐ **Charge Error**

☐ Charges billed in error (Fill out Section 2) *Note: Late charges can be submitted electronically using the ANSI X12 837 claim format.*

☐ Charges incorrect (Fill out Section 2)

☐ **Duplicate Payment**

☐Services paid twice

☐Duplicate Claim No. _____

☐ **Medicare/COB** *Note: COB can be submitted electronically using the ANSI X12 837 claim format.*

☐Coinsurance incorrect (Attach Medicare EOB or other carrier EOB)

☐Paid as primary (Attach Medicare EOB or other carrier EOB)

☐ **Take Back Requested $**

☐ **No Take Back Required (Check Enclosed)** *Please refer to mailing information on the Adjustment Form Instruction sheet.*

Check No. _____ Check Amt. $_____ Check Date _____

☐ **Other Comments:**

Section 2 – Information to be Added, Deleted, or Replaced. (A for Add – D for Delete – R for Replaced) If you require additional space for items that need to be added, deleted or replaced, please use the second page of this form for these items.

Add/Delete/Replace	Date of service	CPT/Revenue Code	Line Charge	# of Units
	Total Charges: $ _____	**Debit + (Pay More) $_____**	**Credit – (Take Back) $_____**	

Anthem's Reply To Provider

☐Claim Forwarded to Processing

☐Claim Will be Adjusted: $_____
Amount Date

☐Payment Applied to Deductible: $_____
Amount Date

☐ Check Voided (See explanation below)

☐Check Will be Reissued

☐Please Send Operative Report

☐Secondary – Refund To Us: $_____

☐Other: _____

Explanation:

Claim Disposition:
☐Paid ☐Denied ☐Processed

Date: _____ Amount Paid: $_____

Paid to: _____

Denial Reason: _____

☐No Record of Billing. Please Resubmit

☐Not an Anthem Member

☐Please send other carrier information

Signature _____ Date _____

***This form and supporting documentation may be faxed to 800-376-0247. Please refer to the instruction sheet for additional addresses for mailing.**

Add/Delete/Replace	Date of service	CPT/Revenue Code	Line Charge	# of Units