

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.**



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