BlueCross BlueShield Kansas
PO Box 211421
Eagan, MN 55121

Provider Refund/Overpayment Request

*Required Fields

Provider Information		
Name*:	Tax ID*:	NPI*:
Contact Name*:	Phone Number*: (including area code):	
For Checks, attach and mail this form to: Blue Cross and Blue Shield of Kansas P.O. Box 2194 Wichita, KS 67201-2194	**For Offsets, fax/mail this form to:** Blue Cross and Blue Shield of Kansas P.O. Box 211421 Eagan, MN 55121 Fax: 1-800-976-2794	
Member/Patient Information		
☐ Kansas BCBS Member	☐ Out of State Member	
Member Name *:	Member ID*: (including alpha prefix)	
Total Check Amount*:	Check Number*:	

Claims/Overpayment Information Using this form authorizes an automatic offset and you will not receive additional notification before the offset is processed.

Overpayment reason*

☐ Claim Overpayment
☐ Void Claim or Charges
☐ Other:
☐ Duplicate
☐ Not our Patient

Enter Claim details. List up to 5 claims for the same patient

Claim Number *:	Date of Service*:	Refund Amount*:
Claim Number *:	Date of Service*:	Refund Amount*:
Claim Number *:	Date of Service*:	Refund Amount*:
Claim Number *:	Date of Service*:	Refund Amount*:
Claim Number *:	Date of Service*:	Refund Amount*:

If you have questions or need further assistance with completing this form, please call Provider Inquiry at 1-800-240-0577.