OPL Deduct Authorization Form

BlueCross BlueShield of Kansas*
www.bcbsks.com

Section 1

The following information must be provided when requesting an automatic deduction due to an OPL-related overpayment.

Provider Name _____ Provider # _____

Patient's Name _____

Insured's Name _____

Identification# _____

Date of Service _____

Total Charge _____

Amount Paid _____

Date Paid _____

Name & Address of Other Insurance _____

Other Insurance ID# _____

Name of Policyholder _____

Other Insurance Payment Amount $ _____

Other Insurance Write-off Agreement Amount $ _____

Section 2

Detailed Explanation of Reason for Refund/Deduct:

Section 3

Please check one:

- ☐ Duplicate Coverage
- ☐ Worker's Compensation
- ☐ No-Fault Auto

Please use this form for OPL Deduct Requests Only.

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