A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Provider Overpayment Form

Use this form to submit any unsolicited refunds related to any claim adjustments.

If this is related to an Accounts Receivable (AR), please use the "other" box and provide the AR number

Submit your payment along with this form to: Blue Cross Blue Shield of Michigan P.O Box 366 Detroit, MI 48231

Fill required information below

Provider's name	NPI number submitted on claim	Patient's name	Contract number (include alpha prefix)	Date of service mm/dd/yy		Internal control number (ICN) or document number	Amount of refund	BCBSM check number if possible	BCBSM check date mm/dd/yy if possible
First name		First name		First	Last				
Last name		Last name							

Check box for reason for refund ☐ Other primary insurance (Coordination of Benefits) not Medicare related ☐ Billing error ☐ Overpayment ☐ Medicare related

☐ Duplicate payment ☐ Other: ____________________

Fill required information below

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First name		First name		First	Last				
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Check box for reason for refund ☐ Other primary insurance (Coordination of Benefits) not Medicare related ☐ Billing error ☐ Overpayment ☐ Medicare related

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If you have questions regarding this form, please call Customer Service.