WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

VOLUNTARY REFUND REQUEST

For Dates of Service Prior to 1/1/2019

Rendering Provider NPI # _____ Provider Name _____

Subscriber ID _____ Patient Name _____

Claim # _____ Total Charges _____

Reason for Refund:

Dates of Service From _____ To _____

Amount Offset Requested $_____

Corrected Total of Claim $_____

INCOMPLETE FORMS WILL BE RETURNED WITHOUT REVIEW

Contact Information Required Name _____ Phone Number _____ Ext. _____

Please send completed form to:

Blue Cross Blue Shield of Wyoming
P.O. Box 2266
Cheyenne, WY 82003
Fax: 307-432-2942

1. Please Include All Applicable: *Case number, date of accident, subrogation information, and/or other insurance information, and other carrier's explanation of benefits.*

Do not send a check. BCBSWY will offset any approved refunds.

Please refer to your future remittance advice for updates.