

# Refund/Deduct Authorization Form



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**The following information must be provided when returning an incorrect payment, or requesting a deduction. If sending a voluntary refund, be certain to attach your check with this form. Thank You.**

Section 1

Provider Name \_\_\_\_\_

Provider Number \_\_\_\_\_

Patient's Name \_\_\_\_\_

Member's Name \_\_\_\_\_

Identification # \_\_\_\_\_

Date of Service \_\_\_\_\_

Total Charge \_\_\_\_\_

Amount Paid \_\_\_\_\_

Date Paid \_\_\_\_\_

Today's Date \_\_\_\_\_

Section 2

**Please check one:**

Refund Check Enclosed  
Cost Center: 830

Deduction Request  
Cost Center: 258

Request Refund Letter  
Cost Center: 258

Section 3

**Detailed Explanation of Reason for Refund/Deduct:**

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