Refund/Deduct Authorization Form

BlueCross BlueShield Kansas

Section 1 – Payment Information

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.

Provider Name

Patient Name

Provider Number

Member Name

_____ /_____ /_____
Date of Service

Total Charge

Member Identification Number

_____ /_____ /_____
Date Paid

Amount Paid

_____ /_____ /_____
Today's Date

Section 2 – Request Type

Please check one.

☐ Refund check enclosed
Cost Center 830

☐ Void entire claim as billed in error
Cost Center 248