

INSTRUCTIONS

ANTHEM MIDWEST PROVIDER INQUIRY/REFUND/ADJUSTMENT FORM

Incomplete forms may be returned without action.

1. Inquiry:	Please check the box that best describes the type of inquiry you are submitting. <input type="checkbox"/> Corrected Claim: Provider is adding, deleting, or replacing charges. <input type="checkbox"/> Underpayment: Provider is inquiring about payment and believes additional payment should be made. <input type="checkbox"/> Overpayment: Anthem paid services twice, paid as primary incorrectly, overpaid allowance, etc. <i>(If an overpayment occurs and money needs to be recouped, we will not provide a written response. The EOB will be your notification that the dollars have been recouped).</i>
2. Type of Inquiry	<input type="checkbox"/> Physician – For all providers billing on a CMS1500 form. <input type="checkbox"/> Dental – For dental claims on CMS1500 form. <input type="checkbox"/> Facility – For all providers billing on a UB92 form. <input type="checkbox"/> Vision – For vision claims on CMS1500 form.
3. Identification Number:	Subscribers' 12-digit identification number, including the three letter alpha prefix.
4. Member Name:	Name of the policy holder.
5. Patient's Name:	Name of person receiving medical services.
6. Account Number:	Identification number assigned to patient by provider.
7. Claim Number:	12-digit number included on Anthem's payment voucher.
8. Service Date/Admission Date:	Date services were rendered, or date patient was admitted.
9. Billed Amount:	Total of billed charges.
10. Provider Tax ID Number:	Provider's 9-digit Federal Tax Identification Number.
11. Anthem Provider Number:	Provider's Anthem assigned personal identification number. (Please include all preceding zeros)
12. Office Contact Name & Phone #	Name of person completing form.
13. Provider's Information:	Please be sure to include provider's name, address, phone, and fax number.

SECTION 1

If additional space is needed for comments, please attach an additional page.

Late Charges:	Charges not included on original bill. Please complete Section 2 with information to be changed that will result in a refund. If adding late charges please be specific as to what charges you wish to add.
Duplicate Payment:	Services paid twice for the same claim. Services paid twice on different claims.
Medicare/COB:	Coinsurance incorrect, incorrect coinsurance paid. Please Attach Medicare EOMB. Paid as Primary – Anthem paid in full without applying Medicare or other carrier's payment.
WC/Subrogation	If Workers Compensation or Subrogation is involved. Please include accident date. Please Attach EOB
Diagnosis Change	If changing diagnosis code originally billed, Please fill in Other Comments section and submit corrected claim.
Charge Error:	Charges billed in error, charges billed incorrectly, charges needing removed from claim, etc. <i>(Complete Section 2 with corrected information.)</i>

SECTION 2

Added	Enter date of service, CPT code, and line charge for the late charges you are adding. See example #1			
Deleted	Enter date of service, CPT code, and line charge for the charges you would like to have removed or credited. See example #2			
Replaced	Enter date of service, CPT code, and line charge for the charges you would like to replace. See example #3			
Add/Delete/Replace	Date of Service	CPT/Revenue Code	Line Charge	# of Units
Example #1 A	8/12/04	99283	40.00	1
Example #2 D	8/12/04	80003	-10.00	3
Example #3 R	8/12/04	80003	30.00	9
	Total Charges \$	Debit + (Pay More) \$	Credit – (Take Back) \$	

<p>If you are sending a refund check with this form, mail to:</p> <p style="text-align: center;">IN – Anthem BC/BS (for IN and OH providers) P.O. Box 7044 Indianapolis, IN 46207-7044</p> <p style="text-align: center;">KY – Anthem BC/BS (for KY providers) P.O. Box 37780 Louisville, KY 40233-7780</p>	<p style="text-align: center;">If you are returning a check issued by Anthem Blue Cross and Blue Shield, please mail to:</p> <p style="text-align: center;">For: Ohio, Indiana, & Kentucky</p> <p style="text-align: center;">Anthem Finance Dept. 1351 William Howard Taft Mail-Point: CW1-262 Cincinnati, Ohio 45206</p>
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IF NO CHECK IS ENCLOSED, PLEASE RETURN PROVIDER ADJUSTMENT REQUEST FORM TO:

ANTHEM BLUE CROSS & BLUE SHIELD
P.O. BOX 37910
LOUISVILLE, KY 40233-7180

