



Provider Refund / Recoupment Form

If you've identified a claims overpayment from Curative or Curative has sent you a request and want to submit a refund to us, see page 2 for instructions on what to include to support your request and ensure timely processing. Specify the reason for the request using one of the descriptions on page 2.

Section 1 – Provider Information

Provider Name: _____

National Provider Identifier: _____

Address: _____

Contact Name: _____

Phone Number: _____

Section 2 – Refund Information

Member ID from PCS: _____ Service Date: _____

Claim Number: _____ Patient's Name: _____

Letter Reference Number: _____ Refund Amount: _____

Provider's Patient Number: _____ Check Issue Date: _____

Check Number (from Curative): _____ Reason / Remarks: _____

Member ID from PCS: _____ Service Date: _____

Claim Number: _____ Patient's Name: _____

Letter Reference Number: _____ Refund Amount: _____

Provider's Patient Number: _____ Check Issue Date: _____

Check Number (from Curative): _____ Reason / Remarks: _____

Member ID from PCS: _____ Service Date: _____

Claim Number: _____ Patient's Name: _____

Letter Reference Number: _____ Refund Amount: _____

Provider's Patient Number: _____ Check Issue Date: _____

Check Number (from Curative): _____ Reason / Remarks: _____

Signature: _____ Date: _____

Your Check Number / Date: _____ Check Amount: _____

Follow these tips when completing the fields on the paper Provider Refund Form:

- **Member ID Number:** Included exactly as they appear on your provider claim summary from Curative.
- **Service Date:** Enter the service date as MMDDYY.
- **Claim Number:** Claim Number as it appears on your EOP from Curative.. Do not use your provider patient number in this field.
- **Check Number (from Curative):** Enter the number of the check you received from Curative as it appears on the EOP.
- **Patient Name:** Include the first, middle initial, and last name of the patient for whom services were rendered by your office.
- **Letter Reference Number:** If applicable, indicate the Request For Claim Refund reference number from the RFCR letter you received from Curative.
- **Your Check Number/Check Date:** Enter the check number for your refund payment and the date of remittance.
- **Amount:** Enter the total amount refunded to Curative.
- **Remarks/Reason:** Specify the reason for the refund using one of the remarks/descriptions below. A specific reason and all supporting documentation must be included for proper review. If your request is missing any required information, we'll return it to you to resubmit. "Overpayment" is not a valid refund reason.
 - **"C.O.B."** – A Coordination of Benefits credit payment was received under two different Blue Cross and Blue Shield memberships or from BCBS and another carrier. (Include a copy of the other carrier's Explanation of Benefits. Do not use for Medicare or Third Party Liability, such as Workers' Compensation.)
 - **"Corrected Claim"** – Payment received for charges that have been corrected. (Include the corrected claim number and/or copy of the corrected claim.)
 - **"Duplicate Payment"** – A duplicate payment has been received from BCBSTX for one instance of service (e.g., same group and member number). (Include the duplicate claim number and/or explanation of benefits for duplicate payment. Do not use for COB, Medicare, Workers' Compensation, or Third Party Liability.)
 - **"Duplicate Payment"** – A duplicate payment has been received from Curative for one instance of service (e.g., same group and member number). (Include the duplicate claim number and/or explanation of benefits for duplicate payment. Do not use for COB, Medicare, Workers' Compensation, or Third Party Liability.)
 - **"Not Our Patient"** – Payment has been received for a patient who did not receive services at this facility/treatment center.
 - **"Pricing"** – The payment from BCBSTX is more than the provider's contracted rate. (Include details of expected reimbursement.)
 - **"Medicare"** – Medicare has paid primary or reprocessed, and payment from Curative has exceeded the Medicare patient liability. (Include a copy of Medicare's explanation of benefits.)
 - **"Billing Error"*** – [This remark may apply if the provider has posted a credit for supplies or services not rendered, or if the provider canceled charge(s) for any reason. You must indicate if all charges were canceled or indicate the specific charges canceled for a partial refund. *This option should not be used if one of the other options applies.]
- **Mailing Address:** Send your completed form, supporting documentation, and refund check to:
 - Curative Health Plan, Attn: Provider Refund, PO Box 1786, Austin, TX 78767