Unsolicited Refunds Form

To submit a refund for claims filed to Blue Cross Blue Shield of North Dakota (BCBSND), please read the instructions and complete this form.

This form is not to be used for standard adjustments. If an adjustment to return or recoup money is unable to be completed due to timeliness, a detailed explanation as to why refund is needed will be required below.

If this form is not filled out in its entirety, it will be returned along with the refund. The request will need to be re-submitted with all required information.

Please return completed forms by:

- Mail: Attn: Finance BCBSND
  4510 13th Ave S
  Fargo, ND 58121

**indicates required field*

Provider Information
Provider Name*
NPI*

Member Information *(only one member per refund request)*	
Last Name*	First Name*
Date of Birth* (mm/dd/yyyy)	Member ID Number*
Claim Number(s)*	
Date(s) of Service* (mm/dd/yyyy)	
Check Number*	

BND-23-0519314 • 9-23

Member Information *(only one member per refund request)*

Reason For Refund* *(Select all that apply)*

- ☐ Billed in error
- ☐ Medicare with Medicare Explanation of Benefits
- ☐ Other insurance to include any Explanation of Benefits
- ☐ Subrogation with Explanation of Benefits from Third Party Carrier
- ☐ No Fault with Explanation of Benefits from No Fault carrier
- ☐ Workers Compensation Explanation of Benefits from Workers Compensation Carrier
- ☐ Duplicate
- ☐ Other – Specific and Detailed reason for refund

Note: *If you are submitting multiple claims for this member with different reasons for refunds, please fill out the checklist but also note the individual claim number and reason in the space below.*

BND-23-0519314 • 9-23