Provider Authorization to Adjust Claims and Create Claim Offsets

Please submit this completed authorization form with all supporting documentation to ensure proper processing of your request to adjust claims, as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

Provider name	
Provider NPI	
Provider tax identification number	
Provider contact information	
Cost Containment project number (if applicable)	
Document identification number (if applicable)	
Total recoupment dollar amount	

Please list claim information below if the Cost Containment letter or other supporting claim/member details are not provided with this request.

Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			
Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			
Claim number	**Member number**	**Service dates**	**Recoupment amount**
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If your request for recoupment exceeds the space provided, please attach an excel file that includes all the data noted above. For questions related to the completion of this form, please call Provider Services at the number on the back of your patient's Member ID card.

I authorize Healthy Blue to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

_____

Print name Signature

Return this form via:
Attn: Cost Containment – Disputes
Healthy Blue
P.O. Box 62427
Virginia Beach, VA 23466-2437
Fax: **1-866-920-1874**

Note: Do not use this form if you are submitting a refund check. If you would like to submit a refund, please use the refund notification form on our website at **https://providers.healthybluela.com**. Mail a check along with the supporting documentation to:

Attn: Cost Containment – Payments
Healthy Blue
P.O. Box 933657
Atlanta, GA 31193-3657