

OVERPAYMENT/VOUCHER DEDUCTION REQUEST



An Independent Licensee of the Blue Cross
and Blue Shield Association

Submitted By	Provider Number	Date
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We request that a deduction be made on our payment voucher for the following:

Patient Name	Patient Account Number	Patient Birth Date
Service Dates		
Subscriber ID Number	Subscriber Name	

Claim Number: _____

Reason for Deduction(s):

Other Insurance Payment

Amount Paid	Patient Responsibility after Primary Carrier Payment
\$ _____	\$ _____
By _____	
Policy Holder _____	Policy Number _____

- Duplicate Payments
 Late Credits
 Cancelled Charges
 Third Party Payment
- Other (Please Specify)

Comments

If Regence BlueShield has questions regarding this request, the person to contact at this provider's office is:

Name	Telephone Number	Time to Contact
_____	_____	_____

SUBMIT REQUEST TO:

BOEING CLAIMS:

Seattle Office – Boeing Claims
ATTN: Mail Stop BU221
P.O. Box 91015
Seattle, Washington 98111-9115

F.E.P. CLAIMS:

Seattle Office – F.E.P. Claims
ATTN: Mail Stop BR480
P.O. Box 21709
Seattle, Washington 98111-3709

ALL OTHER BLUE SHIELD CLAIMS:

Seattle Office
All Other Regence BlueShield Claims
ATTN: Mail Stop S620
P.O. Box 21267
Seattle, Washington 98111-3267