Request to Resolve Provider Negative Balance

All information below is required for BlueCross BlueShield to process your negative balance offset.

Date: _____________

Provider/facility name: ________________________________

Provider ID (where negative balance exists): _________________

Contact name: ________________________________

Phone number: ___________________ Extension: _____________

Voucher date: _________________

Dollar amount returned: _________________

If requesting to transfer balance to active provider:

Provider name: ________________________________

Provider ID: _________________

Additional comments:

Please make check payable to BlueCross BlueShield of Western New York
Attention: Finance Department

Signature: ________________________________ Title: _________________

Date: ________________________________

Fax to: (716) 887-7909

Mail to:
BlueCross BlueShield of Western New York
Attention: Check Control Department
PO Box 80
Buffalo, NY 14203