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

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