Notice of Excess Payment Overpayment (NOEP) Form

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Do not send any payment (cash, check, money order, etc.) with this form. Complete the following required information and any additional information that is not shown clearly on the remit. See detailed instructions on page 2.

1. Contract Holder Information	
Member ID Number required	Group Number
Member Name required	City/State

2. Patient Information	
Patient Name	Patient Account Number

3. Claim Payment to be Recovered		
Remit Date (mm/dd/yyyy) required / /	Claim Number required	Amount Overpaid required
Date(s) of Service (mm/dd/yyyy) required From / / To / /	Total Charge required	Amount Paid
Provider Name	Provider NPI	Tax ID

4. Reason for Payment Recovery required

Select all that apply and include documentation as indicated.

- ☐ Another carrier paid (attach copy of remit)
- ☐ Workers' Compensation paid (attach copy of remit)
- ☐ Duplicate payment (attach copy of remit)
- ☐ Corrected billing (attach corrected billing with all corrections clearly circled)
- ☐ Unable to identify patient
- ☐ Other (explain in space below)

5. Explanation

6. Time Limit Waiver

Sign to agree.

Provider agrees that BCBSAZ may recover this excessive payment notwithstanding any time limits that would otherwise apply.

I am _____, and I verify that the provider agrees to the time limit waiver as stated above.

7. Contact Information			
Name required			
Mailing Address required	City	State	ZIP
Phone Number required	Fax Number		
Date required	Prepared by required		

Fax this form and supporting documentation to BCBSAZ at 602-864-4385 or mail to:

Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, AZ, 85002-3466

Instructions for BCBSAZ Notice of Excess Payment (NOEP) Form

- **Please do not send any payment (cash, check, money order, etc.) with this form.**
- Complete this form for any overpayment identified. Complete a separate form for each claim payment to be recovered and attach legible copies of all related remits. Include all **required** information on the form and any additional information that does not appear, or is illegible on the remit. If unable to provide a remit copy, complete all fields on the form as shown below.
- Fax this form and supporting documentation to BCBSAZ at 602-864-4385 or mail to:

  Blue Cross Blue Shield of Arizona
  P.O. Box 13466
  Phoenix, AZ 85002-3466

1. **Contract Holder Information**
   - **Member ID Number required** – Contract holder's member ID exactly as shown on the member ID card, including all letters and numbers.
   - **Member Name required** – Name of the contract holder.
   - **Group Number** – Contract holder's group number exactly as shown on the ID card. For a Federal Employee Program® (FEP®) member, enter FEP and the 3-digit enrollment code.
   - **City/State** – Contract holder's city and state of residence.
2. **Patient Information**
   - **Patient Name** – Patient's first name, middle initial and last name. In the case of a female patient, always use her given name. For example: Mary J. Johnson, not Mrs. M.J. Johnson or Mrs. John Johnson.
   - **Patient Account Number** – If you include your patient's account number, we will show it on your remittance advice.
3. **Claim Information (for claim payment to be recovered)**
   - **Remit Date required** – Date that BCBSAZ made payment.
   - **Amount Overpaid required** – Amount overpaid by BCBSAZ.
   - **Claim Number (ICN) required** – Internal Control Number from the claim
   - **Date(s) of Service required** – Beginning and ending date(s) of service(s).
   - **Total Charge required** – Total charge on the claim
   - **Amount Paid** – Total payment made by BCBSAZ.
   - **Provider Name** – Name under which claim was processed.
   - **Provider NPI Number** – NPI number under which claim was processed.
   - **Provider TIN** – Tax ID number under which the claim was processed.
4. **Reason for Payment Recovery required** (select all that apply and include documentation as indicated)
   - **Another Carrier Paid** – Attach a copy of other carrier's remit.
   - **Worker's Comp Paid** – Attach a copy of Workers' Compensation remit.
   - **Duplicate Payment** *(for claim processed correctly)* – Attach a copy of the remit.
   - **Corrected Billing** – Attach a corrected billing with all corrections/changes clearly circled.
   - **Unable to identify patient** – Attach a copy of the remit.
   - **Other** – Explain in "Explanation" – see #5.
5. **Explanation**
   - Use this field to provide any pertinent information, in addition to that which is required, that will assist us in processing the payment recovery.
6. **Time Limit Waiver** – There may be a time limit on claims payment recovery provided either by law or your network participation agreement. Sign to agree to waive any applicable time limits.
7. **Contact Information**
   - Enter all **required** information.

Include all additional information to support your request.

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