Credit Balance Adjustment Request Form

Reset Form

Please complete the fields below online & save or print a copy for submission. To save an electronic copy, choose *File* > *Save As* and rename this form to your computer.

Completed forms, along with clear copies of documentation pertinent to all cases submitted for recovery (e.g., previous adjustment request, vouchers or correspondence), may be faxed to the attention of Schaeda Fischer at **1-973-274-2336** or mailed to: **Schaheda Fischer, PP-12P**
Horizon BCBSNJ
P.O. Box 420
Newark, NJ 07101-0420

Name of Facility or Practice: _____

Address: _____ City: _____ State: _____ ZIP: _____

Medicare #: _____ NPI: _____ TIN: _____

Patient Name	Patient ID #	Date of Service MM / YY / YYYY	Credit Amount	Reason for Credit (enter up to three lines per patient)

This form was completed by:

Name: _____ Title: _____ Date: _____

Email Address: _____ Telephone Number: _____