Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

HEALTH ADVANTAGE BILLING ADJUSTMENT FORM for Month _____ Acct Rep* _____
(If Applicable)

Group Name _____ **Division #** _____

Address _____

Telephone _____ **Email Address** _____

Health Advantage
Attn: Membership Accounting
P.O. Box 8069
Little Rock, AR 72203-8069

☐ **Indicate if Change in Group Information**

Division Number	Action Code	Subscriber ID	Subscriber Name	Effect Date M / D / Y (for adds & changes only)	TERM Date M / D / Y (for terminations only)	Contract Type	Explanation	DEDUCT From Bill	ADD To Bill	Net Change

A = Add Member (Application)
D = Cancel Coverage
C = Change in Contract type (Attach Application/Change form)

Contract Type:
EE = Employee Only
ES = Employee/Spouse
EC = Employee/Children
FM = Family

Reason for Cancellation:
Reduction in hours/Terminated employment
Subscriber Request (Attach Subscriber letter)
Deceased

***Group Account Representative is the person that handles the membership and premium for the group at Health Advantage.**

>>>>>>>>>>>> Please attach this Adjustment Form to the Health Advantage bill for the month that is being paid <<<<<<<<<<<<

>>>>>>>>>>>> Please Note: This is the preferred method for submitting changes with your bill <<<<<<<<<<<<

Group Administrator Name _____ **Signature** _____

BILL-ADJ 01/12