

DO NOT use this form to notify us of overpayments including Medicare Secondary Payer (MSP) overpayments

Save time and money, consider using [NGSConnex](#) instead.

Please complete and mail this form with all pertinent documentation (medical records, certificate of medical necessity, operative notes, Advance Beneficiary Notice of Noncoverage, etc.). An * denotes a required field.

Select the state where services were provided:

Jurisdiction K: CT MA ME NH NY RI VT

Jurisdiction 6: IL MN WI

Provider Information	Beneficiary Information
*Name: _____	*Name: _____
Address: _____ _____	*Medicare Beneficiary Identifier: _____
*PTAN: _____	Date of Birth: _____
*NPI: _____	
TAX ID: _____	

Claim Information

*Date of Service: From: _____ To: _____ *Procedure Code: _____

Internal Control Number (ICN): _____ Billed Amount: _____

Are you appealing an overpayment requested by National Government Services? Yes No

Provide the AR Number or Letter Number (if available): _____

***Reason for disagreement with the initial determination:**

- Denied as a Duplicate Incorrectly Timely Filing (explain delay in filing)
 Medical Necessity
 Other: _____

***Note:** This form may be used for multiple claims that all contain the same issue. Attach a copy of the RA and indicate which claims should be corrected.*

Requester Information

*Printed Name: _____ *Signature: _____

Telephone Number: _____ Date Signed: _____

Mail to:

JK: National Government Services, Inc.
P.O. Box 7111
Indianapolis, IN 46207-7111

J6: National Government Services, Inc.
P.O. Box 6475
Indianapolis, IN 46206-6475