

A CMS Medicare Administrative Contractor

## Jurisdiction 6 Medicare Part B MSP Overpayment Request Form

### Claim(s)-Specific Data

Date of Service: \_\_\_\_\_ Overpayment Amount: \_\_\_\_\_  
Medicare Beneficiary Identifier (MBI): \_\_\_\_\_  
Claim Control Number(s): \_\_\_\_\_

Immediate Offset Request:  Allow National Government Services to set up an immediate recoupment for this overpayment request. By checking this box you acknowledge that an immediate recoupment payment arrangement constitutes a voluntary payment and that you may be waiving the right to potential payment of interest pursuant to Section 1893(f)(2) for the overpayment(s). **Note:** Although your overpayment will be offset upon completion of this request, please be aware that a demand letter will still be created for your records.

### Reason for Overpayment

#### Medicare Secondary Payer (MSP)/Other Payer Involvement

07-MSP Group Health Plan Insurance: (working aged, disability, end-stage renal disease [ESRD])  
08-MSP Auto No Fault Insurance  
09-MSP Liability Insurance  
10-MSP Worker's Comp. (Includes Black Lung)  
16-Other \_\_\_\_\_

Complete the following **primary** insurance information and **attach a copy of the primary payer's Explanation of Benefits (EOB)**.

#### Policy Information

Subscriber Name: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Injury Date (if applicable): \_\_\_\_\_  
Related Diagnosis: \_\_\_\_\_

#### Insurer Information

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State and ZIP Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

### Contact Information

Provider Transaction Access Number (PTAN) and/or National Provider Identifier (NPI): \_\_\_\_\_  
Provider Name: \_\_\_\_\_  
Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Provider, Administrator or CFO's signature (someone with authority is required to sign).

### Mail this completed form and primary EOB to:

National Government Services  
J6 Part B MAC MSP Overpayment Recovery Unit  
P.O. Box 6475  
Indianapolis, IN 46206-6475

**Or** Fax this completed form and primary EOB to: **315-442-4151**