national government SERVICES

A CMS Medicare Administrative Contractor

MEDICARE

Jurisdiction 6 Medicare Part A MSP Overpayment Request Form

Claim(s)-Specific Data

Date of Service: _____ Overpayment Amount: _____

Medicare Beneficiary Identifier (MBI): _____

Claim Control Number(s): _____

Reason for Overpayment

Medicare Secondary Payer (MSP)/Other Payer Involvement Select reason

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. (Incudes 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 A MAC MSP Overpayment Recovery Unit
P.O. Box 6474
Indianapolis, IN 46206-6474

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES