National Government Services

MEDICARE

A CMS Medicare Administrative Contractor

Jurisdiction K Medicare Part A MSP Overpayment Request Form

Claim(s)-Specific Data

Date of Service: _____ Overpayment Amount: _____

Beneficiary Health Insurance Claim Number (HICN): _____ 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
JK Part A MAC MSP Overpayment Recovery
Unit P.O. Box 7108
Indianapolis, IN 46207-7108

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES