national government SERVICES

A CMS Medicare Administrative Contractor

MEDICARE

Jurisdiction K Medicare Part A Overpayment Request Form

Claim(s)-Specific Data

Date of Service: _____ Overpayment Amount: _____

Medicare Beneficiary Identifier (MBI): _____

Claim Control Number(s): _____

Reason for Overpayment

Billing/Clerical

01–Corrected Date of Service
02–Duplicate
03–Corrected CPT Code
04–Not Our Patient(s)
05–Mod. Add/Remove
06–Billed in Error

Miscellaneous

11–Veteran Administration
12–Insufficient Doc.
13–Patient Enroll Health Maintenance Organization (HMO)
14–Services Not Rendered
15–Medical Necessity
16–Other - Please Specify: _____

Note: If specific patient/HICN/claim number/claim amount data are not available for all claims due to statistical sampling, please indicate methodology and formula used to determine amount and reason for overpayment:

Note: If specific patient/HICN/claim number information is not provided, no appeal rights can be afforded with respect to this overpayment.

Contact Information

Provider Name: _____

Contact Name:_____ Phone Number:_____Contact Email Address _____

Provider Transaction Access Number (PTAN) and/or National Provider Identifier (NPI): _____

Signature of Requestor:_____ Date:_____

Provider, Administrator or CFO's signature (someone with authority is required to sign).

Mail this completed form to:

National Government Services
JK Part A MAC Overpayment Recovery Unit
P.O. Box 7108
Indianapolis, IN 46207-7108