national government SERVICES

A CMS Medicare Administrative Contractor

MEDICARE

Medicare Secondary Payer Part B Voluntary Refund Form

To be completed by the Medicare Contractor

Date:_____ **Contractor Deposit Control#:** _____

Date of Deposit:_____ **Contractor Contact Name:**_____

Phone Number:_____ **Contractor Fax:**_____

Contractor Address:_____

To be Completed by Provider/Physician/Supplier or Other Entity

Please complete and forward to your Medicare contractor. This form, or a similar document containing the following information, should accompany every unsolicited/voluntary refund so that receipt of check is properly recorded and applied.

Physician/Supplier or Other Entity Name: _____

Address: _____

_____

PTAN #:_____ **NPI#**_____ **Tax ID#**_____

Contact Person: _____ **Phone Number:** _____

Amount of Check $:_____**Check #:**_____ **Check Date:** _____

Refund Information

For each claim, provide the following:

Patient Name:_____ **Medicare Beneficiary Identifier (MBI):**_____

Date of Service: _____ **Medicare Claim Number:** _____

Claim Amount Refunded $: _____

Reason Code for Claim Adjustment: _____ (Reason codes are listed below. Use one reason per claim. Please list all claim numbers involved. Attach separate sheet, if necessary).

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 refund. Providers/physicians/suppliers, and other entities who are submitting a refund under the Office of the Inspector General's (OIG) Self-Disclosure Protocol are not afforded appeal rights as stated in the signed agreement presented by the OIG.

For institutional facilities only: Cost report year(s) _____ (If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements

Do you have a corporate integrity agreement with OIG? ☐ Yes ☐ No

Are you a participant in the OIG Self-Disclosure Protocol? ☐ Yes ☐ No

Reason Codes

Billing/Clerical

01 Corrected date of service
02 Duplicate
03 Corrected CPT code
04 Not our patient(s)
05 Modifier add/remove
06 Billed in error

Medicare Secondary Payer (MSP)/Other Payer Involvement

07 MSP group health plan insurance
08 MSP no-fault insurance
09 MSP liability insurance
10 MSP, Workers' Comp. (including Black Lung)
11 Veterans Administration

Miscellaneous

12 Insufficient documentation
13 Patient enrolled in HMO
14 Services not rendered
15 Medical necessity
16 Other—Be specific:

Mail Completed Form to:

Jurisdiction K
(CT, NY, MA, ME, NH, RI, VT)
National Government Services, Inc.
P.O. Box 809645
Chicago, IL 60680-9645

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES