A CMS Medicare Administrative Contractor

MEDICARE

Jurisdiction 6 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

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 6475
Indianapolis, IN 46206-6475