

## Jurisdiction K Part A Voluntary Refund Form

### 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.

The acceptance of a voluntary refund in no way affects or limits the rights of the federal government or any of its agencies or agents to pursue any appropriate criminal, civil or administrative remedies arising from or relating to these or any other claims.

**Physician/Supplier or Other Entity Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Provider/Physician/Supplier #** \_\_\_\_\_ **NPI** \_\_\_\_\_ **Tax ID #** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Amount of Check \$:** \_\_\_\_\_ **Check #:** \_\_\_\_\_ **Check Date:** \_\_\_\_\_

### Refund Information

For each claim, provide the following:

**Patient Name:** \_\_\_\_\_

**Date of Service:** \_\_\_\_\_ **Medicare Beneficiary Identifier (MBI):** \_\_\_\_\_

**Claim Amount Refunded \$:** \_\_\_\_\_ **Medicare Claim Number:** \_\_\_\_\_

**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/ Medicare Beneficiary Identifier (MBI)/claim number/claim amount data 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/MBI/claim # 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 (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

#### 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:

National Government Services, Inc.  
JK Part A MAC – Voluntary Refund  
P.O. Box 809366  
Chicago, IL 60680-9366