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:____________________ **Health Insurance Claim Number (HICN):**____________________

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	**Medicare Secondary Payer (MSP)/Other Payer Involvement**	**Miscellaneous**
01 Corrected date of service	07 MSP group health plan insurance	12 Insufficient documentation
02 Duplicate	08 MSP no-fault insurance	13 Patient enrolled in HMO
03 Corrected CPT code	09 MSP liability insurance	14 Services not rendered
04 Not our patient(s)	10 MSP, Workers' Comp. (including Black Lung)	15 Medical necessity
05 Modifier add/remove	11 Veterans Administration	16 Other—Be specific:
06 Billed in error		

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