



A CMS Medicare Administrative Contractor

Jurisdiction 6 Medicare Part A 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

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: _____

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
 J6 Part A MAC Overpayment Recovery Unit
 P.O. Box 6475
 Indianapolis, IN 46206-6475

