national government SERVICES

A CMS Medicare Administrative Contractor

MEDICARE

Medicare Secondary Payer Part B Voluntary Refund Form

To Be Completed By Medicare Contractor

Date ______________________ Contractor Deposit Control #: ______________________

Date of Deposit: ______________________ Contractor Contact Name: ______________________

Phone #: ______________________ 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 #: ______________ Email Address ______________

Amount of Check $: ______________ Check #: ______________ Check Date: ______________

Refund Information

For each claim, provide the following:

Patient Name: ______________________ Health Insurance Claim # (HIC#): ______________________

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/HIC#/claim #/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/HIC#/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 (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:

Jurisdiction 6 (IL, MN, WI)

National Government Services, Inc.

P.O. Box 809194

Chicago, IL 60680-9194

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES