national government SERVICES

A CMS Medicare Administrative Contractor

MEDICARE

Jurisdiction 6 Medicare Part B MSP Overpayment Request Form

Claim(s)-Specific Data

Date of Service: ______________________ Overpayment Amount: ______________________

Medicare Beneficiary Identifier (MBI): ______________________

Claim Control Number(s): ______________________

Immediate Offset Request: ☐ Allow National Government Services to set up an immediate recoupment for this overpayment request. By checking this box you acknowledge that an immediate recoupment payment arrangement constitutes a voluntary payment and that you may be waiving the right to potential payment of interest pursuant to Section 1893(f)(2) for the overpayment(s). **Note:** Although your overpayment will be offset upon completion of this request, please be aware that a demand letter will still be created for your records.

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: ______________ Email Address ______________

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 B MAC MSP Overpayment Recovery Unit
P.O. Box 6475
Indianapolis, IN 46206-6475

Or Fax this completed form and primary EOB to: **315-442-4151**

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES