WPS Medicare Part B Non-MSP Refund Form
(Include the check(s) to be refunded and a copy of the remittance notice)
NOTE: A separate form is required for each patient.

From:

_____
Provider/Supplier Name

_____
Address

_____
City, State, Zip Code

_____
PTAN

_____
Tax Identification Number (TIN)

_____
Contact Name

To:

☐ **Iowa**
WPS Medicare Part B
Payment Recovery
P.O. Box 8820
Marion, IL 62959-0902

☐ **Kansas**
WPS Medicare Part B
Payment Recovery
P.O. Box 8830
Marion, IL 62959-0903

☐ **Missouri**
WPS Medicare Part B
Payment Recovery
P.O. Box 8860
Marion, IL 62959-0906

☐ **Nebraska**
WPS Medicare Part B
Payment Recovery
P.O. Box 8850
Marion, IL 62959-0905

_____
Telephone Number

Amount of Check: _____ **Refund Check #:** _____ **Check Date:** _____

Did Medicare Request This Refund? ☐ **Yes** ☐ **No**
If "Yes", indicate the Accounts Receivable Number (this number is on your letter; please include a copy of your letter) _____

OIG Reporting Requirements:
This refund is the result of a Corporate Integrity Program ☐ Yes ☐ No
This refund is the result of an OIG Self-Disclosure Program ☐ Yes ☐ No

Reason Code for Refund…Please check the reason for this refund:

01 ☐ Corrected Date of Service
02 ☐ Duplicate
03 ☐ Corrected CPT Code
04 ☐ Not our Patient(s)
05 ☐ Mod. Add/Remove
06 ☐ Billing Error
07 ☐ Insufficient Documentation
08 ☐ Patient Enrolled in HMO/MCO
09 ☐ Services Not Rendered
10 ☐ Medical Necessity
11 ☐ Patient in SNF
12 ☐ Hospice
13 ☐ Veterans' Administration
14 ☐ Other, please specify: _____

Patient Name: _____ **HICN:** _____ **Date of Service:** _____
Medicare Claim Number (This number is on your remittance): _____
Claim Amount Refunded: _____

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 OIG's Self-Disclosure Protocol are not afforded appeal rights as stated in the signed agreement presented by the OIG.

NOTE: If specific patient/HICN/claim number information is not available for all claims due to statistical sampling, please indicate the methodology and formula used to determine amount and reason for overpayment: