NHIC, Corp.
MEDICARE ADMINISTRATIVE CONTRACTOR
JURISDICTION 14 A/B MAC

J14 MEDICARE PART A OVERPAYMENT REFUND FORM

(DO NOT USE FOR MEDICARE PART B REQUESTS)

SHALL BE COMPLETED BY MEDICARE CONTRACTOR

Date: **Date of Deposit:**

Contractor Deposit Control #: **Phone #:**

Contractor Contact Name: **Fax #:**

Contractor Address:

PLEASE MAKE CHECKS PAYABLE TO MEDICARE AND SUBMIT THE COMPLETED FORM AND CHECK TO:

☐ **New Hampshire/Vermont**
NHIC, Corp,
P.O. Box 809127
Chicago, IL 60680-9127

☐ **Massachusetts/Maine/ RHHI/RI**
NHIC, Corp.
P.O. Box 809086
Chicago, IL 60680-9086

IMMEDIATE OFFSET REQUEST OR VOLUNTARY REFUND REQUEST WITH NO CHECK ATTACHED PLEASE SUBMIT TO:
NHIC, Corp. Part A
P.O. Box 1000
Hingham, MA 02044-1000

SHALL 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.

PROVIDER/PHYSICIAN/SUPPLIER OR OTHER ENTITY NAME:

ADDRESS:

PROVIDER/PHYSICIAN/SUPPLIER # OR NPI#: **TAX ID #:**

CONTACT PERSON: **PHONE #:**

AMOUNT OF CHECK: $ **CHECK #:** **CHECK DATE:**

REFUND INFORMATION

For each claim, provide the following:

Patient Name: **HIC #:** **Date of Service(s):**

Medicare Claim Number: **Claim Amount Refunded: $**

Reason Code for Claim Adjustment: ***(Select reason code from list below. Use one reason per claim.)***

If MSP, list Primary Insurance: **Did Medicare Request Refund? Yes:** ☐ **No:** ☐

Address: City/State/Zip: **If yes, indicate Reference #**

Phone # Insured: **Request for Immediate Offset? Yes:** ☐ **No:** ☐

Employer Policy No: (Written documentation must be attached)

(Please list all claim numbers involved. Attach separate sheet, if necessary.)

NOTE: If specific Patient/HIC/Claim #/Claim Amount data is 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 # 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 or who are under a CIA 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 (Please be specific):

Billing/Clerical
01 – Corrected Date of Service
02 – Duplicate
03 – Corrected CPT Code
04 – Not Our Patient(s)
05 – Modifier Added/Removed
06 – Billed in Error (Please Specify) _____
_____

Miscellaneous
07 – Insufficient Documentation
08 – Patient Enrolled in an HMO
09 – Services Not Rendered
10 – Medical Necessity
11 – Deductible
12 – Paid Wrong Provider
13 – Non-Covered Service
14 – Other (Please Specify) _____

MSP/Other Payer Involvement
15 – MSP Group Health Plan Insurance
16 – MSP No Fault Insurance (Auto)
17 – MSP Liability Insurance
18 – MSP, Workers' Comp. (Including Black Lung)
19 – Veterans Administration
20 – Disability
21 – ESRD