National Government Services

A CMS Contracted Agent

Medicare

Part B Overpayment Recovery Unit 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 #:** _____

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's (OIG's) 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:

Connecticut and New York Providers (all counties)

National Government Services, Inc.
P.O. Box 809645
Chicago, IL 60680-9645

CMS CENTERS for MEDICARE & MEDICAID SERVICES