

Jurisdiction 15 Part B Voluntary Overpayment Refund

SHALL BE COMPLETED BY MEDICARE CONTRACTOR

Date		
Contractor Deposit Control Number	Date of Deposit	
Contractor Contact Name	Phone Number	Extension
Contractor Address		
Contractor Fax		

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 Number	Tax ID Number	
Contact Person	Phone Number	
Amount of Check \$	Check Number	Check Date

REFUND INFORMATION

For each claim, provide the following . . .

Patient Name	Medicare Number
Medicare Claim Number	Claim Amount Refunded \$
Date of Service	
Reason Code for Claim Adjustment	

Select reason code from list below. Use one reason per claim.
Please list all claim numbers involved. Attach separate sheet, if necessary.

NOTE - If specific patient Medicare/claim number/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 Medicare/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 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

Billing/Clerical	MSP/Other Payer Involvement	Miscellaneous
01 – Corrected Date of Service	07 – MSP Group Health Plan Insurance	12 – Insufficient Doc
02 – Duplicate	08 – MSP No Fault Insurance	13 – Patient Enroll HMO
03 – Corrected CPT Code	09 – MSP Liability Insurance	14 – Svcs Not Rendered
04 – Not Our Patient(s)	10 – MSP, Workers Comp. (Including Black Lung)	15 – Medical Necessity
05 – Mod. Add/Remove	11 – Veterans Administration	16 – Other-Please Specify
06 – Billed in Error		

Note - Please include any additional information needed to correctly adjudicate your claim such as which procedure codes and amounts for items returned, primary insurance Explanation of Benefits and detailed reason for Medical Necessity.

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