DME MAC Jurisdiction B Voluntary Overpayment Refund

Provider/Physician/Supplier or Other Entity Information

Date

Please complete and forward to your Medicare contractor at the address or fax number located at the bottom of the form. 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	**City**	**State**	**Zip**
PTAN/NPI Number		**Tax ID Number**	
Contact Person	**Phone Number**	**Amount of Check $**	
Check Number	**Check Date**	**Total Billed Amount $**	

Refund Information

Patient Name	**Medicare Number**	**Date of Service**
Medicare Claim Number	**Claim Amount Refunded $**	

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.

If MSP, list Primary Insurance		**Subscriber Name**	
Subscriber Relationship		**Policy Number**	**Group Number**
Insurer Address		**City**	**State** **Zip**
Telephone Number	**Extension**	**Injury Diagnosis**	**Injury Date**

Must Attach EOB

Note: If specific patient/Medicare/Claim #/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.

Reason Codes

Billing/Clerical

01 – Corrected Date of Service – Date
02 – Duplicate
03 – Corrected CPT Code
04 – Not Our Patient(s)
05 – Mod. Add/Remove
06 – Billed in Error

MSP/Other Payer Involvement

07 – Group Health Plan - Working Aged
08 – Group Health Plan - Disability
09 – Group Health Plan - ESRD
10 – Non Group Health Plan - No Fault/Auto Insurance
11 – Non Group Health Plan - Liability Insurance
12 – Non Group Health Plan - MSP Workers Comp (including Black Lung)

Miscellaneous

13 – Insufficient Documentation
14 – Patient Enrolled in HMO
15 – Services Not Rendered
16 – Medical Necessity
17 – Patient in Skilled Nursing Facility
18 – Items Returned/Picked Up – Date
19 – Other-Please Specify

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**

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.

Make Check Payable to: CGS Administrators, LLC

Please Send to: **CGS**
DME MAC Jurisdiction B
PO Box 953479
St. Louis, MO 63195-3479

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