Provider Name: ______________________ Contact Person: ______________________

Provider Number: ______________________ Contact Number: ______________________

Quarter Ending Date: ______________________

MEDICARE CREDIT BALANCE CORRECTION FORM

Please remove the following Medicare Beneficiary Account(s)
from the Credit Balance Report for the quarter ending: ______________________

1. Name ______________________
   Medicare # ________ ICN # ________ DOS ________ CR BAL $ ________
   Please remove from report for reason stated: ______________________

2. Name ______________________
   Medicare # ________ ICN # ________ DOS ________ CR BAL $ ________
   Please remove from report for reason stated: ______________________

3. Name ______________________
   Medicare # ________ ICN # ________ DOS ________ CR BAL $ ________
   Please remove from report for reason stated: ______________________

4. Name ______________________
   Medicare # ________ ICN # ________ DOS ________ CR BAL $ ________
   Please remove from report for reason stated: ______________________

5. Name ______________________
   Medicare # ________ ICN # ________ DOS ________ CR BAL $ ________
   Please remove from report for reason stated: ______________________

Signature: ______________________

Officer or Administrator of Provider: ______________________

Title: ______________________

Date: ______________________

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