DME MAC Jurisdiction C Overpayment Recovery Request

OPR 412

Note: Please submit one claim per form; include the Medicare Remittance Notice. This form should not be used to accompany a check.

Fax Request to: 1.615.782.4477

Select the type of Overpayment:

Non-MSP ☐ MSP ☐

Provider Information

Facility Name: _____ NPI: _____ PTAN: _____

Contact Name: _____ Telephone Number: _____

Patient Information

Patient Name: _____ Medicare ID number: _____ ICN: _____

Claim Information

Date of Service	Procedure Code	Amount Overpaid

Reason for Non MSP Overpayment (select one)

Enter the appropriate letter from the options below: ____

A - Billed in Error	F - Patient in Skilled Nursing Facility	K - Corrected Date of Service(s)
B - Duplicate	G - Patient in Home Health	L - Corrected Procedure Code(s)
C - Patient Deceased	H - Patient in Hospice	M - Services Not Rendered
D - Items Returned	I - Patient in HMO	N - Veterans Administration
E - Medical Necessity	J - Not Our Patient	O - Other

Reason for MSP Overpayment:

Enter the appropriate letter from the options below: ____

Note: Attach a copy of the primary payer Explanation of Benefits (EOB) or payment information.

A - No Fault Insurance B - MSP Liability Insurance C - MSP Group Health Plan D - MSP Workers Comp including Black Lung

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