# Home Health & Hospice Voluntary Overpayment Refund

## PROVIDER INFORMATION

Provider Name

NPI | PTAN

## REFUND INFORMATION

For each claim, provide the following . . .

**Patient Name** (First/Last) | **Medicare Number**

**Claim's Document Control Number (DCN)** | **Claim Amount Refunded $**

**Date of Service** (From/To) | **Type of Bill (TOB)**

**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 Corporate Integrity Agreement (CIA) are not afforded appeal rights as stated in the signed agreement presented by the OIG.

**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.

**Mail your check and the Overpayment Refund Form** as instructed below (please address to "MSP Overpayment Recovery" if for Medicare Secondary Payer):

**Mailing address for refund checks** (include a cover letter stating the check is being remitted for a voluntary refund):

CGS – J15 Home Health & Hospice
PO Box 957124
St. Louis, MO 63195-7352

**Mailing address for the Voluntary Overpayment Refund Form** and other supporting documentation (include a copy of the check remitted to the St. Louis PO Box address):

CGS – J15 HHH Correspondence
Attn: Voluntary Refunds
PO Box 20014
Nashville, TN 37202

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