



OFFSET REQUEST FORM

For money that Medicare has requested: To initiate a request for immediate offset of an overpayment, fill out the information below. Ensure a copy of the first page, of the original demand letter, is attached to each form. Make certain to complete a separate form for each overpayment to be offset.

For voluntary refunds: Requests for claim adjustments that are submitted via fax will be processed. Providers must fill out the *Offset Request Form* and attach a completed copy of the *Voluntary Refund Form* for each request. Once claims have been adjusted and the accounts receivable created, the debt will be immediately set up for offset. **Please note that a demand letter will still be generated.**

Fax Request to: 1-781-741-3916

Date of Request: _____

Provider / Supplier Name: _____

Provider / Supplier Number: _____

Document Control Number: _____

Amount of Overpayment: _____

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***Beneficiary HICN:** _____

***Claim Number:** _____

***Date of Service:** _____

***Reason for Refund:** _____

**For voluntary refund requests only. These fields are required to ensure proper processing.*

Signature of Requestor: _____