



**DME OVERPAYMENT REFUND FORM
SHALL BE COMPLETED BY MEDICARE CONTRACTOR**

Date: _____	Date of Deposit: _____
Contractor Deposit Control #: _____	Phone #: _____
Contractor Contact Name: _____	Fax #: _____
Contractor Address: _____	
<input type="checkbox"/> Voluntary Refund Check Attached- Please submit to: Medicare Cash Accounting P.O. Box 9143 Hingham, MA 02043-9143	<input type="checkbox"/> Voluntary Refund Check is not Attached- Please submit to: Medicare Overpayments P.O. Box 9175 Hingham, MA 02043-9175
** Make Checks Payable to MEDICARE	

SHALL BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER, OR OTHER ENTITY

Please complete and forward to your Medicare contractor. 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: _____

PROVIDER/PHYSICIAN/SUPPLIER #: _____	TAX ID #: _____
CONTACT PERSON: _____	PHONE #: _____
AMOUNT OF CHECK: \$ _____	CHECK #: _____
	CHECK DATE: _____

REFUND INFORMATION

For each claim, provide the following:

Patient Name: _____	HIC #: _____	Date of Service(s): _____
Medicare Claim Number (ICN): _____	Claim Amount Refunded: \$ _____	
Reason Code for Claim Adjustment: _____	<i>(Select reason code from list below. Use one reason per claim.)</i>	
If MSP, list Primary Insurance: _____	Did Medicare Request Refund? Yes: <input type="checkbox"/> No: <input type="checkbox"/>	
Address: City/State/Zip: _____	If yes, indicate Reference # _____	
Phone # Insured: _____	Request for Immediate Offset? Yes: <input type="checkbox"/> No: <input type="checkbox"/>	
Employer Policy No: _____	<i>(Written documentation must be attached)</i>	

(Please list all claim numbers involved. Attach separate sheet, if necessary.)

Note: If specific Patient/HIC/Claim #/Claim Amount data is 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/HIC/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.

For Institutional Facilities Only: 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: <input type="checkbox"/>	No: <input type="checkbox"/>
Are you a participant in the OIG Self-Disclosure Protocol?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>

Reason Codes (Please be specific):		
Billing/Clerical	Miscellaneous	MSP/Other Payer Involvement
01 – Corrected Date of Service	08 – Insufficient Documentation	16 – MSP Group Health Plan Insurance
02 – Duplicate	09 – Patient Enrolled in an HMO	17 – MSP No Fault Insurance (Auto)
03 – Corrected CPT Code	10 – Services Not Rendered	18 – MSP Liability Insurance
04 – Not Our Patient(s)	11 – Medical Necessity	19 – MSP, Workers' Comp. (Including Black Lung)
05 – Modifier Added/Removed	12 – Deductible	20 – Veterans Administration
06 – Billed in Error (Please Specify) _____	13 – Paid Wrong Provider	21 – Disability
_____	14 – Non-Covered Service	22 – ESRD
07 – Returned Supplies	15 – Other (Please Specify) _____	