



J14 MEDICARE B OVERPAYMENT REFUND FORM
(DO NOT USE FOR MEDICARE PART A REQUESTS)
SHALL BE COMPLETED BY MEDICARE CONTRACTOR

Date: _____ **Date of Deposit:** _____

Contractor Deposit Control #: _____ **Phone #:** _____

Contractor Contact Name: _____ **Fax #:** _____

Contractor Address: _____

Voluntary Refund Check Attached
Please make checks payable to **MEDICARE** and submit to:
NHIC Medicare Part B
P.O. Box 5912
New York, NY 10087-5912

Voluntary Offset Requested
Please submit to:
Medicare
P.O. Box 1000
Hingham, MA 02044-1000

Voluntary Refund Check is not Attached
Please submit to:
Medicare
P.O. Box 1000
Hingham, MA 02044-1000

State service was performed:
 MA VT RI
 NH ME

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: _____ *(Select reason code from list below. Use one reason per claim.)*

If MSP, list Primary Insurance: _____ **Did Medicare Request Refund? Yes:** **No:**

Address: City/State/Zip: _____ **If yes, indicate Reference #** _____

Phone # Insured: _____ **Request for Immediate Offset? Yes:** **No:**

Employer Policy No: _____ *(Written documentation must be attached)*

(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: No:

Are you a participant in the OIG Self-Disclosure Protocol? Yes: No:

Reason Codes (Please be specific):

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