# PART B OVERPAYMENT REFUND/NOTIFICATION FORM

**Check Only One:**
- Part B Overpayment Notification
- Part B Overpayment Notification and Immediate Offset Request
- Part B Overpayment Notification With Check Attached

Mail to address shown below, or FAX request to: Cahaba Part B Overpayment Recovery Unit at **205-220-1530**.

Please complete and forward to Medicare Contractor. This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.

Provider/Physician/Supplier Name____________________

Address____________________

Provider/Physician/Supplier Number __________ NPI __________ Tax ID #__________

Contact Person____________________ Phone Number____________________

Amount of Check $__________ Check # __________ Check Date__________

## REFUND INFORMATION

**For each claim, provide the following:**

Patient Name____________________ HIC Number____________________

Medicare Claim Number (ICN)____________________ Date of Service____________________

Claim Amount Refunded $____________________

Reason Code for 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/HIC/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/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 are not afforded appeal rights as stated in the signed agreement presented by the OIG.

**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

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**Reason Codes:**

**Billing/Clerical Error**
01-Corrected Date of Service
02-Duplicate
03-Corrected CPT Code
04- Not Our Patient(s)
05-Modifier Added/Removed
06-Billed in Error

**MSP/Other Payer Involvement**
07-MSP Group Health Plan Insurance
08-MSP No Fault Insurance
09-MSP Liability Insurance
10-MSP Workers Comp (Including Black Lung)
11-Veterans Administration

**Miscellaneous**
12-Insufficient Documentation
13-Patient Enrolled in HMO
14-Services Not Rendered
15-Medical Necessity
16-Other (Please Specify)
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**Mail to:**

**Submission with a Check:**

Cahaba Medicare Part B
Lockbox 6029
PO Box 7247
Philadelphia PA 19170-6029

**Submission without a check:**

Cahaba Medicare Part B
Overpayments Unit
PO Box 6169
Indianapolis, IN 46206

Signature of Requestor: ____________________ Date: ____________________

*The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.*