



RETURN OF MONIES VOLUNTARY REFUND FORM

This form should be completed fully and accompany each unsolicited/voluntary refund check so that your refund can be properly recorded and applied.

Provider or Other Entity Name

Address

State:

Provider Number

NPI #

Contact Person

Tax ID #

Contact Person Phone #

Amount Returned

Check #

Required Information If Multiple Claims indicate "YES" and include listing

*Patient Name

*Medicare ID #

*Claim Number

Claim Amount Refunded

Date of Service From

Date of Service To

Reason Code for Claim Adjustment

Claim Billed Amount

Additional Info. field

OIG Reporting Requirements

Do you have a corporate integrity agreement with OIG?

Are you a participant in the OIG self-disclosure protocol?

Note: Providers 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.

MSP Information

Other Insurer Information

Employer Information

Insurance Co. Name

Employer Name

Subscriber Name

Employer Address Line 1

Insurer Address Line 1

Employer Address Line 2

Insurer Address Line 2

City State Zip

City State Zip

Policy #

Telephone Number

Telephone Number



Provider or Other Entity Name – Provider/Physician/Supplier/Entity Name

Address - Provider/Physician/Supplier/Entity Address **State** – State services rendered in

Provider Number – Provider Transaction Access Number

NPI # - National Provider Identifier Number (10 digits)

Tax ID # - Provider Tax Identification Number

Contact Person – Name of person to contact if additional information is required

Contact's Phone # - Phone number of contact person if additional information is required

Amount Returned – Total amount of voluntary refund check

Check # - Check number of voluntary refund check

Required Information – If returning Multiple Claims, indicate “YES” in box provided. Include listing of claims with Required Information with check.

Patient Name – Name of patient on claim for which money is being voluntarily returned (Required for Appeal rights)

Medicare ID # - Medicare Beneficiary Identification # on claim for which money is being voluntarily returned (Required for Appeal rights).

Claim Number – Claim Number for which money is being voluntarily returned (Required for Appeal rights)

Claim Amount Refunded – Amount voluntarily returned for specific claim listed

Date of Service From – Date services started for specific claim listed

Date of Service To – Date services ended for specific claim listed

Reason Code for Claim Adjustment – Select appropriate reason code listed under “Reason Codes for each Claim Incorrect Payment”

Claim Billed Amount – Original Billed amount for specific claim listed

Additional Info. Field – To be populated when Reason Codes 01, 03, 08, 09, 10 or 17 are selected.

OIG Reporting Requirements – Select Yes or No to each question.

MSP Information Other Insurer Information (Required if Reason Codes 08, 09 or 10 selected)

Insurance Co. Name – Name of Insurance Company that should have paid as primary.

Subscriber Name – Name of Subscriber to insurance that should have paid as primary.

Insurer Address – Address of Insurance Company that should have paid as primary

City/State/ZIP – City/State/ZIP of Insurance Company that should have paid as primary

Telephone Number – Telephone Number of Insurance Company that should have paid as primary

Employer Information (If Primary Insurance is Provided by Employer)

Employer Name - Name of employer that provided Primary Insurance

Employer Address - Address of employer that provided Primary Insurance

City/State/ZIP – City/State/ZIP of employer that provided Primary Insurance

Policy # - Policy # of Primary Insurance

Telephone Number - Telephone of employer that provided Primary Insurance