J1 Overpayment Refund Form

This form, or a similar document, containing the following information should accompany every voluntary refund to properly record and apply a refund. Please complete and forward to the Medicare address listed below.

Please submit separate forms for MSP and NonMSP requests.

Provider Information
(Must be Completed)

Name: ______________________________________
Address: ______________________________________
____
____
Provider Number: ______________________________
NPI Number: ______________________________
Contact Number: ______________________________
Phone Number: ______________________________

Overpayment/Refund Information
(Use an Attachment if more than one patient.)

Patient's Name: ______________________________
Medicare Number (HIC) (Include Suffix):
____
Claim Number(s) ______________________________
Service Date(s): ______________________________
Procedure Code: ______________________________
Overpaid Amount: ______________________________
Provider/Office Personnel Signature:
____

For OIG Reporting Requirement:
Do you have a Corporate Integrity Agreement with OIG? Yes ☐ **No** ☐

Medicare Secondary Payer Reason For Overpayment

Must be completed for MSP Overpayments. Please ***circle*** *the appropriate number. For multiple overpayments, please attach detailed information. Please include a copy of the primary insurance remittance for the service(s) in question.*

Medicare Secondary Payer (MSP)

01 Group Health Plan Insurance ___________
02 No Fault Insurance ___________
03 Liability Insurance ___________
04 Workers Compensation ___________
05 Black Lung ___________
06 Veterans Administration ___________
07 ESRD ___________
08 Other Insurance Involvement *(Please Identify)*
____

Secondary Insurance:

Insurance Name: ______________________
Insurance Address: ______________________
Insured's Name: ______________________
Employee's ID Number: ______________________
Primary Payer's Allowance: ______________________
Primary Payer's Payment: ______________________
Please send a check for the entire amount of the claim when the primary insurance payer has not been determined.

Non-MSP Reason For Overpayment/Refund

Must be completed for non-MSP Overpayments. Please ***circle*** *the appropriate number. For multiple overpayments, please attach detailed information.*

01 Incorrect Service Date
(Specify Correct Date) ___________
02 Duplicate Payment
(Specify Correct Information) ___________
03 Incorrect CPT Code
(Specify Correct CPT Code) ___________
04 Not Our Patient(s)
05 Modifier Added or Removed
(Specify Correction) ___________
06 Billed in Error ___________
07 Service Not Rendered ___________
08 Medical Necessity Not Met ___________
09 Patient Enrolled in HMO
(Specify HMO) ___________
10 Other
(Please Identify) ___________

Payment Options:

☐ **Immediate Offset** ☐ **Check Enclosed**

All refund checks must be addressed to Palmetto GBA or Medicare. Any checks addressed differently cannot be accepted for deposit.

J1 Medicare Part A
J1 MAC - Palmetto GBA/Medicare
Medicare Part A – Finance & Accounting
P.O. Box 1332
Augusta, GA 30903-1332

Northern California Providers
J1 MAC - Palmetto GBA/Medicare
Medicare Part B – Finance & Accounting
P.O. Box 250
Augusta, GA 30903-0250

J1 Medicare Part B – HI/NV
J1 MAC - Palmetto GBA/Medicare
Medicare Part B – Finance & Accounting
P.O. Box 1416
Augusta, GA 30903-1416

Southern California Providers
J1 MAC - Palmetto GBA/Medicare
Medicare Part B – Finance & Accounting
P.O. Box 550
Augusta, GA 30903-0550