DME MAC Jurisdiction B Overpayment Recovery Request

Note: Please submit one claim per form; include the Medicare Remittance Notice. This form should not be used to accompany a check.

Fax: 1.615.782.4508

Select the type of Overpayment:

Non-MSP ☐ MSP ☐

Provider Information

Facility Name: _____ NPI: _____ PTAN: _____

Contact Name: _____ Telephone Number: _____

Patient Information

Patient Name: _____ Health Insurance Claims (HIC) Number: _____ Claim Number (ICN): _____

Claim Information

Date of Service	Procedure Code	Amount Overpaid

Reason for Non MSP Overpayment (select one)

Billed in Error ☐	Patient in Skilled Nursing Facility ☐	Corrected Date of Service(s) ☐
Duplicate ☐	Patient in Home Health ☐	Corrected Procedure Code(s) ☐
Patient Deceased ☐	Patient in Hospice ☐	Services Not Rendered ☐
Items Returned ☐	Patient in HMO ☐	Veterans Administration ☐
Medical Necessity ☐	Not Our Patient ☐	Other ☐

Reason for Overpayment: MSP (select one)

Note: Attach a copy of the primary payer Explanation of Benefits (EOB) or payment information.

No Fault Insurance ☐ MSP Liability Insurance ☐ MSP Group Health Plan ☐ MSP Workers Comp including Black Lung ☐

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