

DME MAC Jurisdiction C Voluntary Overpayment Refund

Provider/Physician/Supplier or Other Entity Information

Date

Please complete and forward to your Medicare contractor at the address or fax number located at the bottom of the form. 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	City	State	Zip
PTAN/NPI Number	Tax ID Number		
Contact Person	Phone Number	Amount of Check \$	
Check Number	Check Date	Total Billed Amount \$	

Refund Information

Patient Name	HIC Number	Date of Service
Medicare Claim Number	Claim Amount Refunded \$	

Reason Code for Claim Adjustment

Select reason code from list below. Use one reason per claim. Please list all claim numbers involved. Attach separate sheet, if necessary.

If MSP, list Primary Insurance	Subscriber Name		
Subscriber Relationship	Policy Number	Group Number	
Insurer Address	City	State	Zip
Telephone Number	Extension	Injury Diagnosis	Injury Date

Must Attach EOB

Note: If specific patient/HIC/Claim #/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.

Reason Codes

Billing/Clerical	MSP/Other Payer Involvement	Miscellaneous
01 – Corrected Date of Service – Date	07 – Group Health Plan - Working Aged	13 – Insufficient Documentation
02 – Duplicate	08 – Group Health Plan - Disability	14 – Patient Enrolled in HMO
03 – Corrected CPT Code	09 – Group Health Plan - ESRD	15 – Services Not Rendered
04 – Not Our Patient(s)	10 – Non Group Health Plan - No Fault/Auto Insurance	16 – Medical Necessity
05 – Mod. Add/Remove	11 – Non Group Health Plan - Liability Insurance	17 – Patient in Skilled Nursing Facility
06 – Billed in Error	12 – Non Group Health Plan - MSP Workers Comp (including Black Lung)	18 – Items Returned/Picked Up – Date
		19 – Other-Please Specify

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

Note - Please include any additional information needed to correctly adjudicate your claim such as which procedure codes and amounts for items returned, primary insurance Explanation of Benefits and detailed reason for Medical Necessity.

Make Check Payable to: CGS Administrators, LLC

Please Send to: CGS
DME MAC Jurisdiction C
PO Box 955152
St. Louis, MO 63195-5152



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