

OVERPAYMENT RECOVERY REQUEST: MSP

JURISDICTION 15 PART B KENTUCKY & OHIO

OPR 678

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

Fax: 1.615.664.5916 (KY)
1.615.664.5926 (OH)

Select the region in which the services were provided

Provider Information

Facility Name _____
NPI _____
PTAN _____
Contact Name _____
Telephone Number _____

Patient Information

Patient Name _____
Patient Medicare ID _____
Claim Number (ICN) _____

For all adjustments, please send in the Explanation of Benefits (EOB) from the patient's primary insurance.

Type	Primary Payer Allowed Amount	Primary Payer Paid Amount	Obligated to Accept	Line	DOS From	DOS To

Type	Reason for Request	Line

* Note: Supporting documentation is required. Please attach to this request.

CGS Administrators, LLC
PO Box 20018
Nashville, TN 37202

