

Medicare JF Part A Non-MSP Voluntary Checks Form

Please check the box next to the state code where services were rendered:

WA ID OR AK AZ MT UT ND SD WY

Provider/Physician or other entity:

This form should accompany every unsolicited/voluntary refund check. Complete and mail this form along with a check to the address listed on the bottom of this form

Please include the following check information: Make your check payable to Medicare Part A.

Check Number: _____ Check Date: _____

Reason for Refund (For OIG Reporting Requirements)

Corporate Integrity Program OIG Self Disclosure Protocol Voluntary Refund

Required Information:

Please provide the following refund information for each claim.

Document Control Number (DCN)	Medicare Number (HIC)	From Date	To Date	Dollar Amount to be refunded	Procedure Code to be refunded	Reason Code
Total						

If denying or changing CPT codes, indicate the change needed below under 3A through 3B

If the number of claims doesn't fit please include a spreadsheet.

REASON CODE FOR CLAIM ADJUSTMENT

- | | | |
|---|------------------------------|---|
| 1 Billed in error | 4 Corrected date of service | 10 Veterans Administration (VA) paid |
| 2 Duplicate | 5 Not Our Patient(s) | 11 Medical Necessity |
| 3 CPT Code change | 6 Services not rendered | 12 Patient in Skilled Nursing Facility |
| 3A. Deny CPT code in full,
provider to resubmit new code | 7 Modifier Add/Remove | 13 Other: Insert comment below |
| 3B. DOWNCODE , Change CPT
from _____ to _____,
Recoup the difference | 8 Insufficient Documentation | 14 PacMed or USFHP (US Family
Health Plan) |
| | 9 Patient in HMO | |

13 Other: Use the following space for any additional information on the adjustment of this claim(s):

Provider Information:

Provider/Physician or other entity name: _____

Address: _____ City: _____ State: _____ Zip: _____

Provider/PTAN and/or NPI Number: _____ Tax ID#: _____

Contact Person: _____

Telephone Number: _____ Ext.: _____ Fax Number: _____ Ext: _____

Note: If specific patient/HIC/claim Number information is not provided, no appeal rights can be afforded with respect to this refund. Providers/physicians and other entities that are submitting a refund under an OIG Self-Disclosure Protocol are not afforded appeal rights as stated in the signed agreement presented by the OIG.

Please send this form along with a check to: Noridian Medicare JF Part A Refunds - (XX)
(XX represents the state code where services were rendered)
PO Box 511344
Los Angeles, CA 90051-7899
Provider Contact Center (PCC) 1-877-908-8431

