noridian
Healthcare Solutions

JF Part B Medicare Secondary Payer Voluntary Checks Refund Form (Check Enclosed)

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/MSP Voluntary refund check. Complete and mail this form along with a check and EOB(s) to the address listed on the bottom of this form. If you have discovered an MSP clerical error or omission and do not wish to submit a check, please fill out the MSP form located at https://www.noridianmedicare.com/partb/forms/.

Please do not include Non-MSP or Demanded refunds with your MSP Voluntary check.
Please include the following check information: Make your check payable to Medicare Part B.

Check Number: _____ Check Date: _____

Reason for Refund (For OIG Reporting Requirements)
This refund is a result of a ☐Corporate Integrity Program ☐OIG Self Disclosure Protocol ☐Voluntary Refund

Required Information: Please provide the following refund information for each claim.

Internal Control Number (ICN)	Beneficiary Name	Medicare Number	Date of Service	Dollar Amount to be refunded	Procedure Code to be refunded	Reason Code
			Total	0.00		

For additional claims please use the spreadsheet located at
https://www.noridianmedicare.com/partb/
Please use the following space for any additional information on the adjustment of this claim(s):

If the number of claims doesn't fit please include a spreadsheet.
REASON CODE FOR CLAIM ADJUSTMENT

1 MSP Disability
2 MSP End Stage Renal Disease
3 MSP Working Aged
4 MSP No Fault Insurance
5 MSP Liability Insurance
6 MSP Workers Comp
7 MSP Black Lung
8 Veterans Administration, PacMed or USFHP (US Family Health Plan) (Do not use this form use Recoupments Medicare Part B Non-MSP Voluntary Checks Form)

Provider Information:
Provider/Physician or other entity name: _____
Address: _____ City: _____ State: _____ Zip: _____
Provider/Physician and/or NPI Number: _____ Tax ID#: _____
Contact Person: _____
Telephone Number: _____ Ext.: _____ Fax Number: _____ Ext: _____

Medicare Secondary Payer: Complete the following Primary Insurance information and attach a copy of the primary payer EOB and the Medicare EOB.

Insurer Name: _____ Subscriber Name: _____
Policy Number: _____ Group Number: _____
Insurer Address: _____ City: _____ State: _____ Zip: _____
Telephone Number: _____ Ext.: _____ Fax Number: _____ Ext: _____
*Injury Diagnosis: _____ *Injury Date: _____

Note: If specific patient/Medicare Number/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 and EOB(s) to: Noridian Medicare JF Part B Refunds - (XX)
(XX represents the state code where services were rendered)
PO Box 511359
Los Angeles, CA 90051-7914
Provider Contact Center (PCC) 1-877-908-8431

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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