noridian
Healthcare Solutions

Medicare JF Part B Non-MSP Voluntary Checks Form (Check-Enclosed)

Note: Do not use this form for MSP refunds.

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. If this request is due to a clerical error or omission and wish to correct it without having to request a formal appeal, please call the Phone Reopening department at 877-908-8431 or by submitting a reopening form.

Please do not include MSP or Demanded refunds with your non-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)
☐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/forms/
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
2 Duplicate
3 CPT Code change
3A. Deny CPT code in full, provider to resubmit new code
3B. **DOWNCODE**, Change CPT from _____ to _____, Recoup the difference
4 Corrected date of service
5 Not Our Patient(s)
6 Services not rendered
7 Modifier Add/Remove
8 Insufficient Documentation
9 Patient in HMO
10 Veterans Administration (VA) paid
11 Medical Necessity
12 Patient in Skilled Nursing Facility
13 PacMed or USFHP (US Family Health Plan)

14 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/Physician and/or NPI Number: _____ Tax ID#: _____

Contact Person: _____

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

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 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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