DME JD Medicare Secondary Payer Overpayment Refund Form

Supplier 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://med.noridianmedicare.com/web/jddme/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 DME.

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.

Claim Control Number (CCN)	Beneficiary Name	Medicare Number	Date of Service	Dollar Amount to be refunded	HCPCS Code to be refunded	Reason Code
			Total	0.00		

For additional claims please use the spreadsheet located at https://www.noridianmedicare.com/web/jddme/forms
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)

Supplier Information:
Supplier name: _____
Address: _____ City: _____ State: _____ Zip: _____
PTAN 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/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 JD DME
Attn: Refunds
PO Box 511531
Los Angeles, CA 90051-8086

The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

29378848 • 5-18