

**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/jadme/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						

For additional claims please use the spreadsheet located at <https://www.noridianmedicare.com/web/jadme/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              | 5 MSP Liability Insurance | 8 Veterans Administration, PacMed or USFHP (US Family Health Plan) |
| 2 MSP End Stage Renal Disease | 6 MSP Workers Comp        |  |
| 3 MSP Working Aged            | 7 MSP Black Lung          |  |
| 4 MSP No Fault Insurance      |                           |  |

**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 JA DME  
 Attn: Refunds  
 PO Box 511470  
 Los Angeles, CA 90051-8025

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.

